To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate Division of Vital the funeral To the Funeral Director: filled in by completely

Medical Certification:

State Registrar

20. Trad dase reletined to inicalous		Lo.i laco di Boatti (Giloon	drifty drief
examiner? 1 ✓ Yes 2 No	lospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursi	ng Home 5 Residence 6 🗸 Other: Scene
	28e. Place of Injury - At home, farm, street, farm (Specify) found at home an: To the best of my knowledge, death occurred and the basis of examination and/or investigation,	am 1 Yes 2 X No ctory, office building, etc. at the time, date and place, an	28d. Describe how injury occurred subject ingested drugs 28f. Location (Street and Number or Rural Route Number, City or Town, State) 154 Hollingsworth Manor Ellcton, MD d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	and manner stated.	29c. License number	29d. Date signed (Month, Day, Year)
Petri Avoni	-Pollal -	O.C.M.E.	March 4, 2007
30. Name and address of person who o	completed cause of death (Item 23a)		
Patricia Aronica-Pollak MD	Assistant Medical Examiner 11	1 Penn Street, Baltimo	re, MD 21201
31. Date filed (Mon 1 Par Year) 9	007 32. Redistrar's Signature	W	

1052 hrs

10d. Inside City Limits

1 X Yes 2 No

Approximate Interval

Between Onset and

Year

2 No

			For State Registrar	State of	Marylan		artment of <i>rtificate of</i>		and Mental H	ygiene Reg. No.	200	7 00000
0	Physici /Medic		1. Decedent's Name (First, Middle Luther	O.		Bro	own		2. Date of I Month Februa	Day	Year 2007	3. Time of Death 5:50 P. M
	Examir		4a. Facility Name (If not institution,	, give street and numb	er)		4b. City, Town,	or Location o			County of De	
		ч	Northampton Ma				Frede				rederi	
	Funeral Director		5. Social Security Number 215-14-1972	. 57	Age (In yrs. I	la <i>st birthd</i> ay) Yrs.	Months Days			Day, Year)		rthplace (State or Foreign Country) Maryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c City	v. Town or Lo	ecation					10d. Inside City Limits
	e Maryla ka-f shov tified at	ctor	Maryland Frede	rick	,	rederi						M∑XYes 2 No
	th with th 23a or 26 ist be no	Funeral Director	10e. Street and Number 368 Madison Str	eet			10f. Zip Code	701		1	zen of What C USA	Country?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 Tyes 2 If Yes, Give Year or Date	es? ☑ No	1	Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 🛣 No		gin? (Specify Yes or I i, Puerto Rican, etc.)		14. Race - Am Black, Wh Specify:	erican Indian, ite, etc. Black
21215-0036	hin 72 hc e. an "natul Medical	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4	or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most ed)	t of working	16b. Kir	nd of Busines	s/Industry
2	filed within Hygiene. other than "	5	8		ŕ	Minis	ter			M:	inistry	y
pu	be file tal Hy d oth event	To Be (17. Father's Name (First, Middle, I	•				1	r's Name (First, Midd			
yla	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ma	၉	George Washing						lzabeth M.			
, Maryland	1 and 2 sh Health and em 27 is m other traum		19a. Informant's Name/Relationsh Velma Weedon –	1 1 2		90 Wa	verly Dr		Frederick,	Mary	land 2	21702
Baltimore,	Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 13€38 urial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		o	emetery, cre rview	osition (Name of matory or other pla Cemetery	3	Date 3-3-2007	1	cation - City o	r Town, State Maryland
Balt	permit. Page Department of Important: If any Injury of once.		21. Signature of Funeral Service L	igensee " Danull	tall	/	2. Name and Addr 21 Oposs		y Stauffer n Pike, Fr	Funer ederi	ral Hom	ne cyland 2170
No.	Physician	2 16	3a. Part1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death)	a Co	ngest	Tue 1	ter the mode of dy	_		arrest,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed to the has been signed by the attending physician and orgae 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list on ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence as a c	uence of): となれ uence of):	cer wi	to bo	n met	, tas	Le/	Typer
P.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 □ Fetal nt at time of de	Ideath 3	⊒Ectopic pregnand ⊒ Other (specify)	су	-	- 2	23d. Date of d	elivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditio	ns contributing to deat	th but not resu	ulting in the u	nderlying cause g	ven in Part I.			\ .	to the cause of death? Probably 4 ∏Unknown
or Vital Records,		Completed							24a. Wa au pe 1 Yes	topsy rformed?	24b. Were a prior to death?	
/ita	i cian; Th certificate rector, pag	Be C	25. Was case referred to medical examiner?		14			26. Place	of Death (Check onl			
7	Physician; this certific ral director,	은	1 □ Yes ≽BCNo	Hospital: 1 ☐ Inp	oatient 2□	ER/Outpatier	nt 3□ DOA Ot	her: 42Nu	rsing Home 5□Re	sidence 6	Other (Sp	ecify)
Division o	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation	Day Year)	28b. Time o Injury	M 1	Yes 2 1				
Divi	oital or At urs after d sral Direc		4 ☐ Homicide determi	ned 28e. Place of building	, etc. (Specify	()	eet, factory, office		City or 1	Town, State,)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical I one)	g Physician: To the be Examiner: On the bas and manne	is of examinat	wledge, deat tion and/or in	vestigation, in my	opinion, dea	d place, and due to the time the time.	e, date and	place, and di	ue to the cause(s)
	To To COUR	Σ	29b. Signature and title of certifier	in Pier	re			se number	39	29d. Date	e signed (Mor	nth, Day, Year)
	10		30. Name and address of person of	who completed cause	of death (Item	23a) (Type,	· ·		1 1 1			

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 8 2007

			Pleas	e Type or Pri State of M							-		egible.		
		For State Registrar 3-6	5-07 Amend	#23a.Prt.1.Pe	-		-			1101 111	-	Reg. No.	200	7 027	113
Physicia		1. Decedent's Name	e (First, Middle,	Pasqua	ale (Cico	one				2. Date of De Month Februa	Day	, 2007	3. Time of D 12: 35	
/Medic Examin		4a. Facility Name (III		give street and number,)		4b. Cit		r Location of				County of Deat		
Funeral Director		5. Social Security N 146-07-38		Sex 7. A	ge (In yrs. 95	last birth	Month	er 1 Year s Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da NOV 16	th , Year) , 191	9. Birt Nev	nplace (State or i	Foreign
and w		Usual Residence of 10a. State	Decedent 10b, County		10c. Cit	y, Town o	or Location							10d. Inside City	Limits
Maryl.	tor	Maryland	Princ	e George's				Seab	rook					1 TYes 2	2 □ No
h with the 23a or 28a st be not	al Director	10e. Street and Nur 9517 Du	mber ibarry A	venue			10f. 2	Zip Code 20	706			10g. Citiz	en of What Co USA	untry?	
filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Marri 3 □ XVidowed	ned 2 Married	12. Was Decedent Armed Forces 1 12 Yes 2 1 If Yes, Give Year or Dates:	Everin U. ? No WW .	.s. II		edent of Hoecify Cuba	lispanic Orlgi an, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify:		
72 hou	eted	(Spec	15. Decedent's	Education grade completed)		16a. D	ecedent's Us Give kind of v life. DO NOT	sual Occup vork done	ation during most o	of workii	ng	16b. Kin	d of Business/	Industry	
within ene. than "	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5+	5+)	1 '		use retired count				G	overnm	ent	
e filed al Hygi other vent, t	Be Co	17. Father's Name		ast)		1					(First, Middle		-		
ould bound bound but arked	To E		o Cicco								a Delve				
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any Injury or other traumatic event, the Medical Exarone.			rie Cico			95	17 Dub	arry		∍, S	eabrool	k MD			
ages 1 nt of H : If iter			☐Cremation 3	B □Removal from State		cemetery,	Disposition (N crematory o	r other plac	i i		ate		ation - City or		,
nit. Partme bartme cortant Injury		4 ☐ Donation 21. Signature → E	5 ☐ Other (Spe eral Service Li	- 1	Re	surr	ection 22. Name						inton, neral 1	Marylan Home	ια
Der Imp any	0	Pols	nene	Ponds			9013	Annap	olis E	Road	, Lanha	am MD			
Physician /Medical	۷	23a. Part1. Enter the shock, or head Immediate Cause (disease or condition resulting in death)	art fail <u>vire. List o</u> l (Final	oppolications that cause fly one cause on each Preums a	nia mia		Aspira :	tion	Pneumo			rrest,		Approximate Interval Betwe Onset and De	een eath
Examiner	er	Sequentially list co il any, leading to in cause. Enter Under Cause (Disease or	onditions,	b. Due to (or as	s a conseq	uence of		menti	.d						
oe executed cian and ourial-transit	Examiner	Cause. Enter Under Cause (Disease or that initiated events resulting in death) I	S	c. Danen			A								
icate be ex physician a	-	rodaling in doubly i		Due to (or as	s a conseq	uence or)-								
law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 □ 9 □ Unknown	? months? □ No	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al death	3 ⊟Ectopio 5 ⊟ Other		у			23	3d. Date of del Month	ivery Day Ye	ear
uires that n signed by Id be deta	by		ficant condition Failure	s contributing to death	but not res	ulting in t	he underlying	g cause giv	en in Part I.					the cause of dea	
The ate hi	Completed													utopsy findings av completion of cau	
sician: The certificate irector, pag	Be	25. Was case referexaminer?		Hospital:	iont 2	LED/Outp	atient 3	DOA Oth	or:		(Check only o		12 041 /0	Hogr	nice.
ding Phys I. After this funeral dii	ion: To	27. Manner of Deat		1 ☐ Inpat 28a. Date of In (Month, D	jury	28b. Tir		28c. Injur Wor	4 LI Nurs	2	28d. Describe		Other (Spe occurred	cify) Hosp	orce_
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	t be 28e. Place of ir	njury - At ho etc. <i>(Specil</i>	l ome, fam fy)					28f. Location (City or To	Street and wn, State)	Number or Ri	ural Route Numb	er,
ne Hospit 124 hours ne Funera sletely fille	Medical (29a. Certifier (Check only one)		Physician: To the bes xaminer: On the basis and manner s	of examina										
To the within 2	Me	29b. Signature and		20.00				29c. Licens					signed (Mont		7
(12)		1	thia Vi	n Dulle				HO	0058	03	2	2	- 26	- 200	<i>t</i>
DE		Cynthi	ia M. Wi	ho completed cause of lliams, D.0	o. 6	001		ster M	4ill Ro	oad,	Rockv	ille	MD 208	55	
Sta Registr		31. Date filed (Mon			trar's Signa										

Gerald P. Collins	State of Maryland / Department of He 1- For State Registrar State of Maryland / Department of De Certificate of De	ath	2007 D800
Physician/ Medical Examiner		2. Date of Dea Month February	
?		ty, Town, or Location of Death en Burnie	4c. County of Death Anne Arundel
Funeral Director		onths Days Hours Min. Apr 4	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NY
Maryland 28a-f show any 1 at once. ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Glen Burnie		10d Inside City Limits 1 Yes 2 X No
h the Maryland 3a or 28a-f sho otified at once	10e. Street and Number 602 Crain Highway South	Zip Code 21061	log. Citizen of What Country?
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 X Widowed 4 Divorced If Yes, Give Year /2-92 1 Yes	edent of Hispanic Origin? (Specify Yes or No ecify Cuban, Mexican, Puerto Rican, etc.) 2 X No specify: ual Occupation (Give kind of work done	o- 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene other than "natur he Midical Exan	Elementary/Secondary (0-12) College (1-4 or 5+) SFC 17. Father's Name (First, Middle, Last)	working life. DO NOT use retired) 18.Mother's Name (First, Middle,	US ARMY
1215. I be filed ental Hy sarked of vent, the	Unknown Collins	Unknown	
MD 21 2 should th and Me 27 is ma umatic ev		ess (Street and Number or Rural Route Nur ela Road Glen Burnie	
Limore, Pages I and ment of Heal tant: If item or other tra	20a. Method of Disposition 1 Burial 2XX Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (rematory or other plants) Removal from State Metro Cremato	ory 02 27 2007	20c Location - City or Town, State Baltimore, MD
Balt permit. Departs Import injury		and Address of Facility Hardesty F Igely Ave. Annapolis,	Tuneral Home, P.A. MD 21401
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Alcohol Abuse Due to (or as a consequence of):	de of dying, such as cardiac or respiratory arr	rest, shock, or heart Approximate Interval Between Onset and Death
	Sequentially list conditions.		
ted Insit Examiner	cause. Enter Underlying Cause (Jiscass or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
50, te be executed ysician and burial - transit	d. UNPENDED AMENDED		
Division of Vital Records, P.O. Box 68760, note the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Ei	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 5 Other (S		23d. Date of delivery Month Day Year
rices that the signed by be detach		· ·	obacco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be estification: To Be Completed.		24a. Was autop perfo 1 V Yes	psy prior to completion of cause of death?
Vital Recystician: The his certificate director, page	25. Was case referred to medical examiner?	26.Place of Death (Check only one) DOA Other Nursing Home 5	Residence 6 V Other: Scene
Division of Vispinal or Attending Physispida or Attending Physispida or Attending Physispida or Affer this filled in by the funeral diffication: To Certification: To	27 Manner of Death 28a Date of Injury 28h Time of Injury	28c. Injury at Work? 28d. Describe	how injury occurred
Divis pital or A purs after eral Dire filled in b	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact (Specify)	ory, office building, etc. 28f. Location (sor Town, S	Street and Number or Rural Route Number, City State)
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b			
¥ , , ,	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 17, 2007
/x/	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Str	reet, Baltimore, MD 21201	
State Registrar			
DHMH 17 Rev 1/2001			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 0^{Y2}ar 9:39 ALEX CURRY JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**™**M 2□ F Months Days Hours Min AUGUSI" f2, 1931 251-42-1946 75 SOUTH CAROLINA Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 Yes 2 No Director WASHINGTON DC N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 1229 G. ST. SE #12 20003 U.S.A. 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must t death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. should be filed within 72 hours after ound Mental Hygiene.

marked other than "natural", or Iter 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 Yes 2 No Specify: ģ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life_DO NOT use retired). TRUCK_DRIVER Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Be ANNA MAE JACKSON ALEX CURRY SR. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8905 BLACKBRIAR CT. FT. WASHINGTON, MD 20744 MARY DEAS/SISTER item 27 i tem 27 i 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or ott CLINTON, MD RESURRECTION CEMETERY3/2/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES, P.A. 21. Signature of Funeral Service Lice 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Thenoscleration disease or condition resulting in death) 54eas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy perform 25**(**No 1☐ Yes funeral director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 KER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဠ 1 ☐ Inpatient 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Year) 1 Natural 2 Accident To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

State Registrar

(Check only

29b. Signature and title of certifier

livingsta 1/4/1/ fort UAKUsta Mn 20744 M.D. 11701 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year SUZANNE S. February 22, 2007 4:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore Baltimore City If Under 1 Year | tf Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2X F 82 Yrs. **Director** 212-20-1099 08-04-1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or itama 23a or 28a-f ahow Examinar must be notified at 1 X Yes 2 No Maryland Prince George's Hyattsville Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3200 Kimberly Road 20782 U.S.A. Funeral filed within 72 hours efter deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Btack, White, etc. 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry D.C. Air Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 National Guard <u>Personnel Specialist</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pages 1 and 2 should be filt Depertment of Heelth and Mantal Hy Important: if Itam 27 is marked oth any liny or other traumatic avent 2008: Robert Spindle Suzanne Kidwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Lee Whalen - Daughter 3200 Kimberly Road, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 02/27/2007 Bladensburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyatusville, MD 20781 11111 233 Part1. Enter the disease, or confinications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician dryngeal cancer 1eaks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed ettending physicien end for use es the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 405 PICE 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Division To the Hospital or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours e To the Funeral C completely filled to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eutaw St Bullimore Richey Hospice 32. Registrar's Sign State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 0539 PITTMAN L. CAREY, JR march 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL 50/15/04/1 HICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Days Director 57 212-36-1823 02/10/1950 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD Pocomoke Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b USA by Funeral 8073 Bowlend Road 21851 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White er than "natura", the Markeal E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none Farmer <u>Agriculture</u> is marked other permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Pittman L. Carey, Sr. Emily Groton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris J. Miller Carey/Wife 8073 Bowlend Road, Pocomoke, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 3/3/2007 Salisbury, Maryland Signature of Fun Jal icensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11673 Somerset Ave., Princess Anne, MD 21853 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHIONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) as t attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No as been signed by the 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown molbia 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate ha 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

Box 68760. P.O. 1 Division or Vital Records. Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

Registrar

Medical

31. Date filed (Month, Day, Year)

affetto

MAR 0 5

2007

29a, Certifier

30. Name a

Joe

(Check only one) 29b. Signature and title of cer

400 E. Shore

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

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			For State Registrar				-	Cei	rtificate of	Dea	th		Reg. No	20	7	00000
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	Physicia /Medic		Paul A.	Doer	son							Februa	ry 2	5, 20	007	9:55 A ^M
)	Examin		4a. Facility Name (If not inst. 714 McKnew Ro		e street and nu	ımber)			4b. City, Town,		ion of Death		1 .	. County of		
			5. Social Security Number		Sex	7. Age	e (In vrs. I	last birthday)	Gambri If Under 1 Yea		ider 24 Hrs.	8. Date of Bir	th	nne A		de⊥ lace (State or Foreign
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2	filed within 72 hours after death with the Maryland Hygiene. Hygiene, than "natural" or items 23a or 28a-f show ther than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Dive		Armed F 1 7 Yes If Yes, G Year or I	2□1 ive	No Kor		If Yes, specify Cu 1 □ Yes 2 N			Rican, etc.)		Black, Specify:	White, Whi	
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2	and 2 sealth ar		Martha Gull	ey Da	ughter.	-in-	·Law	1064	ng Address <i>(Stre</i> B ri ght	Leai	Drive	Arnold	, MD	21012	2	•
ני פו	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Intropriant: if them 27 is marked other than "natural;" or items 23a or 28a-f show important: if them 27 is marked other than "natural;" or items 20a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Crema 4 □ Donation 5 □ Oth			State	20b. P	Place of Disponentery, cres	sition (Name of matory or other p lge Ceme	lace) tery	Feb.	Date 28,07		ocation - C	•	
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	s been si	Completed										24a. Was		24b. W	ere auto	psy findings available
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical Co				basis o	f examina	tion and/or in	h occurred at the	v opinion	death occur	red at the time.	date an	d place, at	nd due tr	the cause(s)
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	ね,		30. Name and address of pour state of pour s	Ma	ruan	se of d	eath (Item	1 23a) (Type,	fol Dr	ive	Gler	n Bu	~	ie, N	۱۵.	Day, Year) 26, 2007 21061
	Sta Registr		31. Date filed (Month, Day,	7 20	07	negistr	ar s Signa	A So	W.							

		For State Registrar	State of Mar	• '	artment of H			giene	7 08009
22		Decedent's Name (First, Middle, Last)		•,,		2. Date of Dea	ath	3. Time of Death
Physic /Med		VERONICA GRAC	E DOVE				Februa		2007 2:44 a ^M
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	th	4c. County of	of Death
1985 A. S.		Washington Advent			Takoma If Under 1 Year	Park If Under 24 Hrs		Montgo	
Funeral Director		5. Social Security Number 6. Se	X 7. Age (In yrs. last birthday) On Yrs.	Months Days	Hours Min	. (Month, Da		9. Birthplace (State or Foreign Country)
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1215-0036 within 72 hours after death with the Maryland and. then "naturel", or iteme 23s or 28s-f show then "naturel" are mailtied at	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (9 in, Mexican, Puei	Specify Yes or No- to Rican, etc.)	14. Race Black	- American Indian, , White, etc.
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2 short and the man	0	19a. Informant's Name/Relationship (T)			g Address (Street a				
Te, M		Jeffrey Dove - S	on			Street,			land 20737
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show eny injury or other treumatic event, the Madical Examinar must be natified at once.		20a. Method of Disposition 1 X Burial ∕2 Cremation 3 □ I	Removal from State	20b. Place of Dispo cemetery, cren	stion (Name of natory or other plac	e)	Date	20c. Location - C	City or Town, State
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Bai permin Depar Impo		21. Signature of Funeral Service Lidens	68		. Name and Addres	•			Baltimore Ave.
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Box 68 Bath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date Mont	of delivery th Day Year
.O. I the de ty the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at tir 9 Unknown	ne of death 5	Other (specify)				
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Division of the or attending Phy after death. Director: After this tin by the funeral din	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	- At home, farm, str	eet, factory, office		28f. Location (S City or Tox		r or Rural Route Number,
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Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exami	sician: To the best of e	my knowledge, death	occurred at the time	ne, date and place	e, and due to the	cause(s) and man	ner as stated.
To the H within 24 To the F complete	Medicai	One)	and manner state	d.					
Will To	<	29b. Signature and title of certifier	Id-+	- L M.P	29c. License				(Month, Day, Year)
0 160		1	Y	111	D52	326		February	23, 2007
() (10)		30. Name and address of person who co							
~	ate	James Kennedy Lig 31. Date filed (Month, Day, Year)	ntioot, Jr	MD W	ashingtor	Advent	ist Hosp	ital, Tal	koma Park, MD
Regist		FFR 2 8 2007	an DA	Signature.					

		For State Registrar	State o	f Maryland /		rtmen tificate			and M		giene Reg. No. ?	007	08010
Physicia		1. Decedent's Name (First, Middle, La	st) genes	Cada	De	asis				2. Date of De Februa	Day	Year 5, 2007	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, given Doctors Community		mber)		L	anham	Location o	of Death			ounty of Death nce Geor	ge's
Funeral Director		213-90-314/	Sex I∐XM 2∏F	7. Age (In yrs. last 58	<i>birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Dec. 12	th ay, Year) , 1948		place (State or Foreign intry) illippines
ermit Pages 1 and 2 should be filed within 72 hours after death with the Maryland eparment of Health and Mental Hygiene. pparment of Health and Mental Hygiene. mporamer: If them 27 is marked other than "natural", or items 23a or 28a-f show ny in ury or other traumatic event, the Medical Examiner must be notified at no.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge 10e. Street and Number 11410 Fort Saratoga 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last Patricio 19a. Informant's Name/Relationship Felicita Veluz / Signature of Jugeral Service) 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Special Service) ice	1 Court 12. Was Dec Armed For 1 Yes Give For Decided Completed) College (4 t) Deasis (Type. Print) Ster	edent Ever in U.S. orces? 232 No ive orces: 1-4or 5+) 20b. Plac cen	Washi 13. 16a. Dece (Give life. Ed 19b. Mailli 3210 2e of Disponetery, cress Cress	ngton 10f. Zip 20 Was Decedif Yes, spe 1 □ Yes dent's Usus kind of woo DO NOT us ucator g Address Barcr osition (Namatory or or patory) 2. Name ai	744 dent of Hickory dent of Hickory al Occupant done of the control al (Street & oft D me of other place and Address	Specify: ation furing mos 18. Mother and Numb rive (ss of Facili	er's Name Felis Fer or Rurr Sprin 103/04/	e (First, Middle ta Ca al Route Numi gdale, M Date	o- 14 s 16b. Kind a, Maiden S da ber, City or 1 laryland 20c. Loca Edger Calas Fi	in of What Course of Black, White Specify: Fill of Business/life Course of C	nes ican Indian, , etc. ipino industry on ip Code) if Town, State aryland ome PA
death certificate be executed Amedical Examiner e attending physician and id for use as the burial-transit	ledical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a consequence) O (or as a consequence) O (or as a consequence)	nes ofy:	iore	ney	O.	iscu u	12			yeurs
he death cert the attending	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live	utcome pf pregnand birth 2 □ Fetal d gnant at time of dea nown	leath 3	□Ectopic p □ Other (s		4			23	3d. Date of del Month	ivery Day Year
w requires that the death certificate been signed by the attending phe should be detached for use as it		Part II. Other significant conditions	contributing to	death but not result	ing in the	underlying	cause giv	en in Part	I.	1[Yes 2] No 3 □ Pr	the cause of death? robably 4 Unknown
The la ate has page 2	Completed							00 Pl-		24a. Wa auf per 1 Yes	topsy rformed? 22 No	24b. Were at prior to death?	utopsy findings available completion of cause of 2 No
tending Physicath. tor: Affer this the funeral dir	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could now determine	28a. Dat (Mo		28b. Time Injury	М	28c. Injui Woi 1 🗆	ner: 4□N	lursing H	ome 5 ☐ Re 28d. Describ	sidence 6 e how injury	f Number or R	ural Route Number,
Hospita 24 hours Funeral	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer: On the	he best of my know basis of examination	ledge, dea	ath occurre investigation	d at the ti	ime, date opinion, d	and place eath occu	e, and due to the time	ie, date and	place, and du	e to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	Ruen	and the second		2	9c. Licens	se number	40	2	Feb	e signed (Mon	th, Day, Year) 26, 2007
(7)		30. Name and address of person w Sheven Remser	no completed ca	use of death (Item: 575Ma	23a) (Type	Print) Freet	- Su	ito:	351,	hacer	rel, m	71), 0	26,2007
St	tate	31. Date filed (Month, Day, Year) FER 2 8 2007	hair 32	Registrar's Signatu	19 Miles	,	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - U 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Florence Lucy Dudley February 23, 2007 0100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Rehab & Nursing Center Burtonsville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F Months Director 016-07-3053 Mar 26, 1910 Vermont Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b County 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6627 Deep Run Parkway 21075 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify þ 3℃ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Self Employed Entrepreneur permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Importent: If item 27 is marked ofth.
any injury or other treumails. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elias Stowell Minnie Robinson ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Wedeking Daughter 6627 Deep Run Pkwy. Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2☐€remation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 2/23/07 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitaritts Funeral Home & Chapel, PA 412 Washington Kd. Westminster, MD 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** posclerdh /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of Injury 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours. To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI Restection 23, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo Ms BOB ROLD MU 25

DHMH 17 Rev 1/2001

State Registrar 31. Date liled (Month, Day, Year)

6

2007

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

		•	State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygien Reg. N	2001 00012
			Decedent's Name (First, Middle, Last)		2. Date of Death Month D	3. Time of Death
	Physicia /Medic		Robert LeRoy Davidson		2. 27	7 2007 7:00 A. M
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			4202 Black Rock Road	Hampstead		Carroll
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	Director	-	217-12-2090 03		8/27/1921	Maryland
	and and	-	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Live	ocation		10d. Inside City Limits
	vlaryl f ehc	ō	MD Carroll Hampstead			1 ☐ Yes 2 📉 No
	the 128a-	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	3a or		4202 Black Rock Road	21074	Uni	ited States
	me 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
۵	after or ite		Armed Forces? 1 Never Married 2 Married 1 Mayes 2 No 1942— If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 V No Specify:	Hican, etc.)	Black, White, etc.
200	ours Fig.	1 by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1945	1 ☐ Yes 2 🔀 No Specify:		Specify: White
ۍ د	72 h natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work		Kind of Business/Industry
1215-0036	he he	ldu	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		G
7	be filed within 72 hours after death with the Maryland thygiene. Hygiene. do that than "naturel", or iteme 23a or 28a-f ehow event, It.e Moulcal Examinar must be notilised at		9 Mana 17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	arm Supply Company
ä	0 m 5	Be				
2	should be nd Mental marked o	ဥ	Earl Davidson 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Grace Swing Address (Street and Number or Rur		y or Town, State, Zip Code)
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o,	ss 1 and 2 should to the standard that the standard the standard to the standard to the standard to the standard to the standard the st		20a Method of Disposition 20b. Place of Disp			Location - City or Town, State
2			1 M Burial 2 □ Cremation 3 □ Hemoval from State	matory or other place)	007	
Baltimore, Maryland 21	permit. Pag Department Important: f eny injury o		DC. PHIX S	(Snydersburg) 3/2/2 2. Name and Address of Facility 77		pstead, Maryland
8 —	Per Cop fmp		Slaven W. Eline M00723 M	^{2. Name and Address of Facility} Eli ain Street, Hampst	ne funeral ead, Maryl	Land 21074
П			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between Open and Death
	nysician		Immediate Cause (Final disease or condition	he Right lung w	ith meta	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	0		
	1	e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).			
	nsit	를	cause. Enter Underlying Cause (Disease or injury			
<u>.</u>	death certificate be executed e attending physician and id for use as the burial-transit	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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89	tificate ng phys as the					
Вох	eath certific attending p	N/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetel death 3	Ectopic pregnancy		23d. Date of delivery
	e deal	Physiclan/Me	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
<u>Б</u>	that the de led by the a detached f	P.	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	and adding a super part to Dood to	22a Did tobasa	o use contribute to the cause of death?
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9	w require been si should l	etec	Chiebnic Obstractibe Tarifordan	7 4136436	-	
ec €	elaw hast ie 2 s	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
			VALUE STATE OF THE		1 Yes 2 1	
<u> </u>	siciar certif recto	Be	25. Was case referred to medical examiner?	04	th (Check only one)	2 Tay 10 11
ō	Physical displays	٠ <u>.</u>	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how in	6 ☐Other (Specify) sjury occurred
on		ê	15 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 □ Yes 2 □ No		
/IS	or Attending Physician: after death. Diractor: After this certifics in by the funeral director.	flca	3 Suicide 6 Could not be	reet, factory, office		and Number or Rural Route Number,
á	in Diffe	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St	ai <i>e</i>)
	To the Hospitel or At within 24 hours after of To the Funeral Dirac completely filled in by	edlcal	29a. Certifier (Check only one) (Check only one)			
	o the	Mec	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
)	15/1		Penny U. Jane Ma	7/2901	11.	127/07
	12/14		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	1 +7	1 101 (1
	Ψ		1000 1000	ckleysville Road, H	1 Ampslea	9,1421074
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 .	1	
	Regist	di	FEB 2 7 2007 Shows It	gosili)		

State of Maryland / Department of Health and Mental Hygiene

			For State Of Ma	arylariu /	Certificate of L	Death	Reg	. No.2 0 0 7	03013
	Physicia	an	1. Decedent's Name (First, Middle, Last) PATRICIA ANN DI M	ITSA			Date of Death Month ebruar	Day 26 Year y 200	3: Time of Death 37 6:52 AM
	/Medio		4a. Facility Name (If not institution, give street and number)	IIDA	4b. City, Town, or		ebruar	4c. County of Dea	th
	E X A I I I I I	CI	Civista Medical Center		LaP1at			Charles	
	Funeral Director		579-50-0891 1□M 2X F	je (In yrs. last 69	t birthday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Y) EC 21,	ear) Co	thplace (State or Foreign ountry) HINGTON DC
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
	e Mary la-f sh tiffed a	ctor	MARYLAND CHARLES		WALD	ORF			1 ☐ Yes 2 No
,	death with the Maryland ms 23a or 28a-f show r must be notified at	I Director	10e. Street and Number 2308 PINEFIELD ROAD		10f. Zip Code	20601	10g	. Citizen of What Co UNITED	
7 CIO	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1	1	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 █ X No		y Yes or No- can, etc.)	14. Race - Ame Black, Whi Specify:	erican Indian,
+ £	72 hour 'natural dical Ex	Completed t	15. Decedent's Education (Specify only highest grade completed)	1	16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation Juring most of working	16	Sb. Kind of Business	
VQ₩	within ene. than "	duc	Elementary/Secondary (0-12) College (1-4or	5+)	HOMEMAKE			OWN HOM	E
192	e filed Il Hygi other vent, t	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Ma	uiden Surname)	
Z ar	Menta Menta arked atic ev	10 E	ROBERT J. SHELTON			INEZ M.			
S.A. Marylánd	d 2 sho th and ?7 Is ma trauma		19a. Informant's Name/Relationship (Type. Print) KATHY M. HUGHES - DAUGHTER		19b. Mailing Address (Street at 2301 PINEFIEL			•	
Baltimore,	Pages 1 and ent of Health of: If item 27 by or other t		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		ce of Disposition (Name of netery, crematory or other place LNGTON NAT L.		H	Dc. Location - City of	r Town, State VIRGINIA
Baltil	permit. I Departm Importal any inju		21. Signature of Funeral Service Licensee M. Wart & Roshaum	100053	22. Name and Addres	ss of Facility HUN ASHINGTON	TT FUNE RD., WA	RAL HOME LDORF, MD	
	Physician	7 ()	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I Immediate Cause (Final disease or condition	d the death. I	Do not enter the mode of dyin Acute Kidr	g, such as cardiac or	respiratory arres	st,	Approximate interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as	a consequent	Acute Kidr noe of): atic Kidne	y Can	cer		Months
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_6	execute and al-trans	Examiner	that initiated events resulting in death) Last	a consequer	nce of):				
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/ital	ysiclan: is certifica director, p	Be C	25. Was case referred to medical examiner?		Lou	26. Place of Death			
or \	Physic this corral dire	2	1 Yes 2 No Hospital: 1 Inpat		R/Outpatient 3 DOA Oth	4 LI Nursing Hom		nce 6 Other (Sp	ecify)
on	nding Ph th.: After this funeral	tion:	1 Natural 5 Pending (Month, D		Injury Wor	k? Yes 2 □ No		,,	
Divisi	l or Atter after dea' Director	Certification:	3 Suicide 6 Could not be 28e. Place of in	njury - At home etc. (Specify)	e, farm, street, factory, office	28	Bf. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
_	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fun	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the bess and manners and manners	of examinatio	edge, death occurred at the tip on and/or investigation, in my o	me, date and place, as opinion, death occurre	nd due to the car d at the time, da	use(s) and manner a te and place, and di	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier R. Sindl	won	29c. Licens	6 1 6 1 4	29 Fa	d. Date signed (Mor	nth, Day, Year) 26, 200 7
	Ç		30. Name and address of person who completed cause of				/(wan y	- /
,	DB10		Ravinder K. Sindhwani		O Pembrook S	Sq. Suite	304 W	Waldorf,	MD 20603
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Regis						

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ustin Robert Do		Sta 1-For State Registrar	ate of Maryland		tment of l ificate of l		nd Menta	, ,	eg. No. 20	107 08	011
Physicia Medical Exami		Decedent's Name (First, Middle	_{e,Last)} Justin Roł	ort D	ov.o.1.1			Date of Dear Month	th Day Yea	3. Time of Dear	
		4a. Facility Name (if not institution				. City, Town, o	r Location of	March 8, 2	4c. County (
Funeral		Union Hospital 5. Social Security Number	6. Sex 7. A	ge (In yrs. las		Elkton If Under 1 Ye	ar If Under	24Hrs IR Data of Rin	Cecil th(MM/DD/YYYY	9. Birthplace (State or	
Director		218-15-7915 Usual Residence of Decedent		26	Yrs.	Months Da		Min	, 1981	Foreign Pennsy1v Country)	ania
/ any	1	10a. State 10b. County		10c. City, T	own or Location	1				10d. Inside City	
e Maryland or 28a-f show <u>fied at once.</u>	ţō	Maryland Ceci	1	E1k				1		1 Yes 2	XNo
with the Maryland is 23a or 28a-f sho	Director	130 Farah Driv	10			10f. Zip Code 21921		10	Og. Citizen of Wh	States	
hours after death with the Maryland matural", or items 23a or 28a-1 she Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Ma	12. Was Deceder			Decedent of Hi	ispanic Origir	n? (Specify Yes or No- Puerto Rican, etc.)		- American Indian, Blac	:k,
fter dea !", or it			1 Yes 2 orced If Yes, Give Year	X No	-	es 2 X No		,	Specify:	White	
hours ad natural Examin	ed by	15. Decedent's Education (Spec			16a. Decedent's		ation (Give ki	nd of work done	16b. Kind of Bu		
72 3 -	Completed by	Elementary/Secondary (0-12)	College (1-4 or	5+)	Labo			,	Wareh	INTISE	
215-0036 be filed within rintal Hygiene. riked other tha vent, the Medic		17. Father's Name (First, Middle,						Name (First, Middle, M	Maiden Surname)		
MD 21215-0036 nd 2 should be filed within 7 th and Mental Fygiene. m 27 is marked other than aumatic event, the Medica	lo Be	Robert Dean Do			19b. Mailing A	Address (Stre		nda Lynn Gr er or Rural Route Num		n, State, Zip Code)	
re, MD 21215 1 and 2 should be file Health and Mental Hy filem 27 is marked o		Robert D. Dowe	ell/Father	Loo. Di				1kton, Mar		1921 City or Town, State	11/1
Baltimore, MD 212 permit. Pages I and 2 should by Department of Health and Ment Important: If item 27 is markingury or other traumantic even		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Sp			ace of Disposition of the Pry Hill			March 10, 2007		Hill, Maryl	land
Saltir ermit. E Separtme mporta njury o	İ	21. S nature of Funeral Service		Tricti	22. Na Hic	me and Addres	s of Facility for T		P.A.	Maryland 219	Land
Physician	-	23a. Part I. Enter the disease, or		d the death. [103 Do not enter the	W. Sto	ckton , such as car	Street, El diac or respiratory arre	Lkton. Mest, shock, or hea	art Approximate I	Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	a. Methadone							Between Ons Death	
		or condition resulting in death) Sequentially list conditions,	Due to (or as a cons	sequence of):							
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ox 68760, eath certificate be es attending physiciar for use as the burial	In/Me	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?	23c. If yes, outco	ome of pregna	ancy	death 3		pregnancy	23d Date of Month	delivery Day Ye	ear
ox 6 eath cer attendi	sicia		4 Pregnant a	at time of deat	· =	r (Specify)					
that the d red by the		Part II. Other significant conditi		th but not res	sulting in the und	derlying cause	given in Part			ibute to the cause of dea	
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al Rec an: The ertificate ctor, page	Be Co	25. Was case referred to medical				26.Plac		Check only one)	2 10 1	✓ Yes 2	No
f Vital Physician: er this certif	108	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpat		R/Outpatient 28b. Time of Inju		Other ₄ ury at Work?		Residence 6		
ion of tending Ph. eath.	tion:	1 Natural 5 Pend	ing Fnd 3/27	Year)	Fnd 11:55		Yes 2X	i			
Divisi pital or Att ours after de eral Direct	Certification:	3 Suicide 6 X Coul	d not be 28e, Place of	Injury - At hon	ne, farm, street,		building, etc.	or Town S	tate)	er or Rural Route Numbe	er, City
		29a Certifier 1 Certifying Pt	nysician: To the best of	ny knowledge	e, death occurre	d at the time, o	date and plac	e, and due to the caus	Dr. Elkt e(s) and manner	r as stated.	
To the Howithin 24 h	Medical	one) 2 Medical Exam	miner: On the basis of ex and manner stated	amination and	d/or investigatio			urred at the time, date			
	Σ	29b. Signature and title of certifie	11/11/2				se number .M.E.		March 8, 20	ed (Month, Day, Year) 007	
ń		30. Name and address of person		,			D - 14"	MD 04004	L		
₩ S	ate	Melissa Brassell, MD 31. Date filed (Month, Day, Year)	Assistant Medica	al Examine ar's Signature		nn Street,	Baltimore,	MD 21201			
Regis			007 Meseus	J.	Sperk						
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Anneste Marie Ellsworth March 8, 2007 'ver J2:05 Braining As Feeling Name of rear statistical grow above and as Feeling Name of rear statistical grow above and as Feeling Name of County Death 1 (1) and pr 1 / 89 of year ast commonly statistic var 1 (1) and pr 1 / 89 of year as to commonly statistic var 1 (1) and pr 1 / 89 of year as to commonly statistic var 1 (1) and pr 1 / 89 of year as to commonly statistic var 1 (1) and pr 1 / 89 of year as to commonly statistic var 1 (1) and pr 1 / 89 of year as to commonly statistic var 1 (1) and pr 1 / 89 of year				Fied Set 1 - State Registrar	State of Mary	/land / De		Health and I	Mental Hygi	•	7 08015
4. Secult Name (if not installation, give since and number) Buckfugham's Choice Health Care 5. Social Security Number: 4. Social Security Number: 5. Social Security Number: 4. Social Security Number: 4. Social Security Number: 4. Social Security Number: 5. Social Security Number: 4. Social Security Number: 5. Social Security Number: 4. Social Security Number: 5. Social Security Number: 5. Social Security Number: 5. Social Security Number: 6. Sex Security Number:	Phys	sicia	an				F11 or row+1		2. Date of Death Month	Day Yes	3. Time of Death
Usual Residence of Decedent 10c. City, Town or Location 10d. Inside 10d. State 10c. County 10d. State 10d. County 10d. State 10d. County 10d. State 10d. County 10d. City 10d. County 10	/Me	edic	al	4a. Facility Name (If not institution, gir	ve street and number)			n, or Location of Death			
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Specify Spec	Ba-f ehow		ector	10a. State 10b. County Maryland Fr		Oc. City, Town or	Adams				10d. Inside City Limits 1 ☐ Yes 2√ No
Specify Spec	3a or 3		i Dir		cle		10f. Zip Cod		10	-	
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Physician /Medical Examiner Physician /Medic	Depart Depart Import	Buc	1 Home								
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The standard death Last Column Col	uted I Insit		miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	onsequence of);				<u> </u>	Weeks
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24a. Was an autopsy performed? 24a. Was an autopsy findings prior to completion of death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manger of Death 28a. Date of Injury 28b. Time of Injury 28b. Ti	quires ination signed by ald be deta		Ď	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause	given in Part I.			e to the cause of death? Probably 4 □Unknown
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Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 3 Suicide 4 Homicide 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Route Number or Ru	ortificat ctor, p		0					26. Place of Dea			es 2 No
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28 Place of Injury - At home, farm, street, factory, office 28 Place of Injury - At home, farm, street, factory, office 28 Place of Injury - At home, farm, street, factory, office 28 Place of Injury - At home, farm, street, factory, office 28 Place of Injury - At home, farm, street, factory, office 28 Place of Injury - At home, farm, street, factory, office 28 Place of Injury - At home, farm, street, factory, office 29 Pla	After t		 	1 Natural 5 ☐ Pending	(Month, Day Ye				28d. Describe how	v injury occurred	
29a. Certifier (Check only (C	all or Autena after death i Director: d in by the		ertificat	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury -	At home, farm, Specify)			28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
and maintained States	ne nospiu in 24 hours he Funeral pletely filled		edicai	29a. Certifier (Check only one) Certifying Plants Certifying Cert	hysician: To the best of m miner: On the basis of exa and manner stated,	y knowledge, de amination and/or	ath occurred at the investigation, in m	time, date and place, y opinion, death occur	, and due to the cau rred at the time, date	use(s) and manner te and place, and d	as stated. lue to the cause(s)
March 9, 2007	with Tot		Σ	· allen	Keil	ly m	0				
30. Name and address of person who completed cause of death (IJM 23a) (Type, Print) Allen Reilly, M.D., 801 Toll House Avenue, Frederick, Maryland 21701	10							Frederical	« Marvla	nd 21701	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 33. Date filed (Month, Day, Year)				31. Date filed (Month, Day, Year)	31 Registrar's		Avenue	TEGGLICI	i rai y Ear	21/01	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Cy 200 8:09A M Glennette Everett Linda arch /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 310 Pennsylvania Avenue Allegany Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days Hours Min 1 □ M 2 □ F Vrs MD Oct 11. Director 220-40-2194 63 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once. 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits MD Allegany Cumberland Be Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 Pennsylvania Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 □ XVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) June Lease Clay Adam Scarpelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kelly Everett daughter 310 Pennsylvania MD 21502 Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/9/2007 Scarpelli Funeral Home, P.A. MD 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown 21. Signature Funeral Service Lio 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cute Myocardial Infarction
Due to (or as a consequence of): 24 hrs. Acute /Medical **Examiner** Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical After this certificate has been signed by the attending physi funeral director, page 2 should be detached for use as the i IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation м the 1 within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) th. 29b. Signature and title f certifie 29c. License number 29d. Date signed (Month, Day, Year) D23371

Registrar
DHMH 17 Rev 1/2001

State

625 Kent Avenue Cumberland MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oamar Zaman M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB. **Physician** 224 **20**07 10:00p M ANNIE L. EARLY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. MAY On the Day | 1928 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 🛠 🖫 F 78 577-38-2711 Director NORTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location CLINTON 10a, State 10h County 10d. Inside City Limits show 1√Yes 2 No PRINCE GEORGES MD a or 28a-f shot be notified a Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a Examiner must b 8207 BATHGATE COURT U.S.A. Completed by Funeral 20735 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the filed of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21☑ No Specify. BLACK Specify: 3 N Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) OWNED HOME than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANNIE HILYER AUGUSTUS SURRATT ပ္ 19a. Informant's Name/Relationship (Type. Print)
BARBARA J. POWELL / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8207 BATHGATE CT. CLINTON, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/5/07 SUITLAND, MD WASHINGTON NATL. CEM. 21. Signature of Funeral Service Licens 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES, P.A. Wart Xonu 6500 ALLENTOWN RD.CAMP SPRINGS, MD 20748 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart indure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular accident disease or condition resulting in death) UNKnow-/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy perform 1□ Yes 2 🔊 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Funeral Director: After To the Hospital of within 24 hours af

death with the Maryland

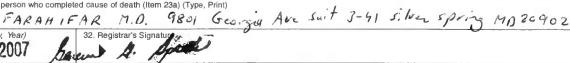
3altimore, Maryland 21215-0036

10 State Registrar

31. Date filed (Month, Day, Year) FEB 2 8 2007

ROIN TAN

29b. Signature and title of certifier



7.0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year) 2.26.07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** FEB. 26, RACHELLE CATHLEEN EVANS 2007 1628 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 1 □ F 30 214-08-1302 NOV. 14, 1976 WASHINGTON, D.C. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No MD PRINCE GEORGES LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9060 STEBBING WAY, APT. D 20723 UNITED STATES Funeral ould be filed within 72 hours after death Mental Hygiene. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 👿 No Specify þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other than đ CHEF FOOD SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be trment of Health and Ments tant: If item 27 is marked jury or other traumatic e OTIS TALLEY, JR. BRENDA BOLDEN TALLEY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUSTIN EVANS - HUSBAND 9060 STEBBING WAY, APT. D, LAUREL, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 03/06/07 CHELTENHAM, MD 21. Sign are of Funeral & rvice of nie ROAD, INDIAN HEAD, MD 20640 LYDIA C. THORNTON JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or/ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit the death certificate be executed Due to (or as a g P.O. Box 68760 attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate Division or Vital 1 25. Was case referred to medical examiner? YE Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🔲 Inpatient ER/Outpatient 3□ DOA After this Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

completely filled in by the funeral director, death. within 24 hours after death To the Funeral Director:

Medical

State Registrar

ö

the Hospital

OPESANMI

6 ☐ Could not be

and manner stated

1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of person who completed cause of death (Item 23a) (Type, Print)

anim

MD7503 SURRATTS ROAD, CLINTON, MD 20735

31. Date filed (Month, Day, Year) MAR 0 1 2007

3 ☐ Suicide

29a. Certifier (Check only one)

29b. Signature a

4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of M	laryland		artmen <i>rtificati</i>			ind Me		21	007	080	119
			Decedent's Name (First, Middle, Last	t)			imour	0, 0	704111	2	2. Date of Deat		<u> </u>	3. Time of	Death
	Physici /Medio			NORVAL E	UGENE	EYLER				Fε	ebruary	25,	2007	9:20	АМ
	Examin		4a. Facility Name (If not institution, give)		4b. City,	Town, or	Locetion of	Death			unty of Deat	h	
			9602C Rocky Ridge 5. Social Security Number 6. Se		ge (In yrs. las	t hirthdoul	Rock	y Ri	dge If Under 2	A Hrs o	t. Date of Birth	Fred	lerick	nalana (Ctata	a Causina
П	Funeral Director			M 20F 1.0	80	Yrs.	Months	Days	Hours	Min.	Month, Day,	Year)	Co	nplace (State o untry) vland	or roreign
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	ehow	_	10a. State 10b. County		10c. City,									10d. Inside C 1 ☐ Yes	-
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	within 72 hours after death with the Maryland ene. than "naturel", or lieme 23a or 28e-f ehow the Medical Examinar must be notified at	Funeral Director	9602C Rocky Ridge	Road				1778			, ,		U.S.A	•	
	death	Jera	11. Marital Status	12. Was Deceden		13. \	1		spanic Orig	in? (Speci	fy Yes or No- can, etc.)	14.	Race - Ame	rican Indian,	
စ္	or ite	Fur	1 Never Married 2 Marned	Armed Forces 1 ☐ Yes 2 1 ☐ If Yes, Give			iYes, spec I∐Yes :		n, Mexican, Specify:	Puerto Re	can, etc.)	İ	Black, White	e, etc.	
21215-0036	urel',	d by	3X Widowed 4 □ Divorced	Year or Dates:										hite	
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פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)		'						First, Middle, A				
yla	Ment Ment arked	To	Bruce P. Eyler						Luti	e Sir	iger				
Maryland	12 sh h and 7 Is m traum	0 4	19a. Informant's Name/Relationship (T)	,, ,							Route Number,	-			
ė,	1 and Health em 2 ther i		Ralph L. Eyler / S 20a. Method of Disposition	5011	20b. Plac	e of Dispo			age. K	oad,	Rocky		on - City or l		
nor	ages ant of it: If It		t ØBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		cem	Ch •	natory or o	ther place	ethre	n 2/2				e, Mary	land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Iteme 23a or 28e-f ehow any fujury or other traumatic svent, the Medical Examinat must be notified at Once.		21. Signature of Funeral Service License								N FUNE				
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	Pnysician	8	Immediate Cause (Final disease or condition		state.	1								Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):	Rau	Ò.	£						
		Ē	Sequentially list conditions if any, leading to immediate	Due to (or as	a consequer	nce of):	pour	- 011	ext 6						
	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		chre H	,	Failu	٠,							
o Ô	The law requires that the death certificate be executed te has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Exa	resulting in death) Last		a consequer										
8760	hysici the bu	dicai		d											
9	death certifica ettending pl d for use as t	/Med	IF FEMALE:	23c. If yes, outcome	of pregnance										
Вох	eath c	cian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetel de	eath 3	Ectopic pro						Date of deli		Year .
Division of Vital Records, P.O.	that the death cer ed by the ettendir detached for use	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			, o (op.								
ώ. σ	signed k	y P	Part II. Other significant conditions co	ntributing to death	out not resultin	ng in the ur	nderlying ca	ause giver	n in Part I.		23e. Did tob	acco use c	contribute to	the cause of c	leath?
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<u> </u>	I or Attending Ph after death. Director: After th in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of In	jury - At home tc. (Specify)	e, farm, stre	et, factory	, office		281	f. Location (Str. City or Town	eet and Nu State)	ımber or Ru	ral Route Num	ber,
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	To the Hospital or Attenswithin 24 hours after deatl To the Funaral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best iner: On the basis of and manner si	of examination	dge, death and/or inv	occurred a restigation,	in my opi	e, date and inion, death	place, and occurred	d due to the ca at the time, da	use(s) and ite and plac	manner as ce, and due	stated. to the cause(s)
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1	2	1	30. Name and address of person who co		death (Item 23	За) (Туре, І	Print)								
			Kelly P. Miller	c, MD G	ettysb	urg,	PA			<u> </u>					
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 8 20)07 32. Jegist	ran's Signativ	A	me								
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Registrar
DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

2007

Idlewild Avenue Easton, MD

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yes **Physician** FEBRUARY 23 EMMA RUTH EASON 5:22PM [™] 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILLIAM HILL MANOR **EASTON** TALBOT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1□M 2XF Yrs 85 JULY 6, 1921 MARYLAND Director 219-05-8870 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked to the than "natural; or litems 23a or 28a-f show any injury or other traumatic event. It is Marildal Examinat must be notified at any injury or other traumatic event. It is Marildal Examinat must be notified at Yes 2 No Director **EASTON** MD TALBOT 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 501 DUTCHMANS LANE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FLOYD WILMER COLEMAN ဂ EMMA M. FLUHARTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA L. EASON/DAUGHTER 313 SEYMOUR AVE., ST. MICHAELS, MD 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY | 2/28/2007 EASTON, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRIOSN ST EASTON, MD 21601 *Joseph 37 STLowshi Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nanition Physician resulting in death) /Medical Due to (or as a consequence of) brovascular Accident Examiner Sequentially list conditions, I any, leading to initial actions. Enter Underlying Cause (Disease or injury Examiner burial-transit certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Records, P.O. Box 68760. the attending physician Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by þe 1 Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 1442187 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Conword Dr Easton int 21601 555 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Freeze St.

Registrar's Signature

7 2007

FEB 2

			For 1 = State Registrar	State of	Marylan				ealth a Death		_	giene Rag. No.		7	0802	2
			1. Decedent's Name (First, Middle, I	_ast)							2. Date of De Month	Day	,	Year	3. Time of De	ith
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	Funeral Director		5. Social Security Number 6. 220-01-1268	. Sex 7.	95	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Dec. 1	v Year)	911	Cour	lace (State or Fo http: Tand	reign
			Usual Residence of Decedent								DCC	., .	J	11017	Tarra	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							1	0d. Inside City L	
	B Ma	cto	Maryland Fred	derick				Wood	sboro)					1 🔁 Yes 2[_No
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	it em	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 ☐ Yes 2	es?	.5. 13.	If Yes, spe	ecify Cuba	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.))-		, White,		
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Maryland 21215-0036			Betty Eyler/ day				N. S∈				odsboro				(0000)	
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Division of	i Pie	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ad 289. Place of	Injury - At h	ome, farm, sti fy)	reet, facto	ry, office			28f. Location (City or To			r or Rura	l Route Number	
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	To the within 2 To the I complet	Σ	29b. Signature and title of certifier	~			29	c. License	nu <i>m</i> ber			29d. Dat	e signed	(Month,	Day, Year)	
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	7		30. Name and address of person wh	o completed cause	of death (Iter	-11	4		. 7	P	C- 1-	- 1	M i	1 7	1700	
8			31. Date filed (Month, Day, Year)	NULLYEN	strar's Signa		esm	mou	m yy	we,	near	nai	IM	u	1700	
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DHMH 17 Rev 1/2001

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	/Medic	al			A.		45 Cit. 7		Location of		Feb. 2		2007 County of De		4:10 M
	Examir	er	4a. Facility Name (If not institution, given Fort Washington		,		1		hingt		MD		P.G.	ed (1)	
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs.	last birthday)	If Under		If Under 2 Hours		8. Date of Bir (Month, Da	th V Year	9. 8	Birthplace ((State or Foreign
	Director		214-51-2462	□ M X□ F 7	6	Yrs.	Months	Days	riouis	WINT.				hiopi	
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	or 28a	by Funeral Director	10e. Street and Number				10f. Zip	Code				-	itizen of What	-	
	23a c	aiD	4208 Flam Street				2	0744				Et	thiopia		
	er dez	nue	11. Marital Status	12. Was Deceden Armed Forces	?	.S. 13.	Was Decede If Yes, speci	ent of His fy Cubar	spanic Orig 1, Mexican,	gin? (Spe , Puerto I	cify Yes or No Rican, etc.))-	14. Race - Ai Black, W		dian,
36	Ir, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ₹ If Yes, Give Year or Dates			1 ☐ Yes 2	X No	Specify:				Specify: E	thio	pian
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f ahow fra Mudical Exain ar must be confilled at	ted	15. Decedent's Ed	ducation		16a. Dece	dent's Usual	Occupa	tion	of models		16b. K	Kind of Busine	ss/industry	,
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and	d be f	To Be	Debebe Gebrewold								Abeyou		ii Sumaine)		
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timore,	Pages 1. nent of He int: if iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ 4 □ Denation 5 □ Other (Specification of the content of the conte			Place of Dispo emetery, crer • Micha	natory or oti	her place		3/4	/07		ocation - City is Abal		State thiopia
Canti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if itam 27 is marked other than "naturat", or items 23a or 28a-f ahow any injury or other traumatic avent, it a Mulical Exact are must be called at once.		21. Signature of Funeral Service Lider			22	2. Name and	Addres	s of Facility		ier's I enue, I				
68760,	Physician be executed // Medical ing physician end physician be as the burial-transit	Medicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c. Due to (or a d.	s a consequence of the consequen	uence of):	er the mode	of dying), such as o	7	r respiratory a		Q	Inter	roximate val Between et and Dijath
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n O	ding Phy h. After thi funeral	ino i	27. Manner of Death 1 ②Natural 5 □ Pending	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe I	how inju	iry occurred		
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	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	edicai	29a. Certifier 1X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bes niner: On the basis and manner s	of examina	wledge, death tion and/or in	n occurred a vestigation,	it the tim in my op	e, date and inion, deat	d place, a h occurre	and due to the ed at the time,	cause(s date an	s) and manner d place, and d	as stated. ue to the o	ause(s)
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DHI	MH 17 Rev 1/2	001			T.										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death GANNAWA: Physician Day Month bert 200 2025 /Medical 0 24 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 306 Charred Oak Court Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Nov. 11, 1939 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex. XXM 2□ F 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign Days Months Hours Mary Land Vre Director 214-38-8154 67 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 Director Maryland | Anne Arundel Annapolis 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23a 306 Charred Oak Court 21401 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

MAYes 2□ No 1962−
If Yes, Give Year or Dates: 1968 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after Black, White, etc. 1XXXNever Married 2 ☐ Married 1 ☐ Yes XXNo White Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Frozen Food Manager Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donovan F. Gannaway Kathryn Marie Wayson permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 Is mar any injury or other traumati 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn A. Beggs / Sister 8391 Hamburg State Park Rd. Mitchell, GA 30820 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Hallows Cemetery 2/28/2007 Davidsonville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ceroselerotic /Medical ue to (or as a consequence of): Examiner betes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Te to (or as a consequence of) The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Physician/Medical as nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autonsy certificate 1∐ Yes 2 No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 2 Accident 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier

To the Hospital within 24 hours a To the Funeral C completely

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

· JONES, MD

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29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DE 17 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year It Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 'ATHERNES MURSING-COUTER REDEVILL 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 293-14-9882 1 M 2 P Ohio Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or iteme 23a or 28a-f ehow event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Carroll Westminster Directo 10f. Zip Code 10g. Citizen of Whal Country? 10e. Street and Number 1162 Canon Way 21157 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Deperment of Heelih and Mental Hygiene. important: If item 27 is marked other than "natural", or Iten eny injury or other treumatic event, the Medical Exembrat 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) High School Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul Greenwald Schneider 2 Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jane A. Gilbert Daughter Erin Way Bel Air, MD 21015 Feb. Date 9, 200 7^{20c.} Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Kremation 3 Removal from State South Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, M 21784
Approximate
Interval Between
Onset and Death Winfield, MD 21. Son ture of Funeral Service Lion s dim. auun 23a. art1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Imm viate Cause (Final disease or condition resulting in leath) LEFT LOWER LOBE **Physician** /Medical Due to (or as a consequence of): Examiner ALZHERMERS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HOVANCED Due to (or as a consequence of): Examine ed by the ettending physicien and detached for use as the buriel-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by I should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Stonknown PERPOUSION FIBLUATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examined 1 Dres 2 No Hospital: 1 Inpatient 2 1No 1 Yes certificate 2 No : After this certifical funeral director. 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 5 Pending nours efter death. neral Director: Aft filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours of the Funeral Examining Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29c. License number Wi h 29b. Signature and title of certifier 02-17-07 spartar

State Registrar

31. Date filed (Month, Day, Year)

FEB 2

4:45 Amel

30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

Anarth)

4910-A Fairfield Rd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 26, 2007 ERNEST **GATES** 12:51 A M WTT.I.TAM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7800 ANN HARBOR DRIVE PORT TOBACCO CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 8, 1921 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 1(XM 2□ F MARYLAND 577-20-5634 85 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 ☐XNo MARYLAND CHARLES PORT TOBACCO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7800 ANN HARBOR DRIVE 20677 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. XYes 2□No 1943-1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced 1954 Year or Dates: WHITE Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PLUMBER CIVIL STEAM FITTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THEODORE PHILLIP GATES ANNIE LAURIE RAUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET T. GATES - WIFE 7800 ANN HARBOR DR., PORT TOBACCO, MD 20677 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State FEBRUA'RY 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 27, 2007 4 □ Donation 5 □ Other (Specify) HUNTT CREMATORY WALDORF, MARYLAND 22. Name and Address of Facility HUNTT FUNERAL HOME 21. Signature of Funeral Service M00053 3035 OLD WASHINGTON RD., WALDORF, MD 20601 notan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hepatocellular CARCINOMA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery eath 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month 5 Other (specify) regnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 00 24a. Was an autopsy performed?
1 ☐ Yes 2 D No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 2 Accident

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Box 68760. use as the į P.O. detached the Division of Vital Records, page 2 should be certificate has

Examiner Physician/Medical ۾ Be Completed Certification: To

IF FEMA

funeral director, this after death. filled in by 24 hours a completely

Physician

/Medical

Examiner

10a State

Funeral

Director

rthan "natural", or Itama 23a or 28a-f aho the Medical Examiner must be notified at

other then

of Health and Mental Hygis If Item 27 Is marked other in other traumatic event, III

≃ ö permit. Page Department o Important: If any Injury or once.

Physician

/Medical

Pages 1 and 2 should be fit tment of Health and Mental Health and marked others:

Funeral Director

Completed by

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

29a. Certifier Medical

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

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BIE	1

within 2 To the I

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State Registrar

ALE:	23c. If yes, outcome of pregnanc
s decedent pregnant he past 12 months?	1 Live birth 2 Fetal de

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D35206

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) haven an

11731 Livington Road Fort WASHington una

anny

6 Could not be determined

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6 2007 40 A **Physician** March Mildred A. Houghton /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 21X F 203-20-6948 12-16-21 Director Pennsvlvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one. 1 ☐ Yes 2√ No PA Adams Fairfield Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17320 20 Grasshopper Lane USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2√√No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify white Completed by 3√ Widowed 4 Divorced 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Asst. Module Manager Social Security Admin. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Miller Hazel McClain ဝ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Morton, grandson 2705 Overview Drive Hampstead, Maryland 21074 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation North Memorial 3 ☐Removal from State 03-09-07 4 ☐ Donation 5 ☐ Other (Specify) Northumberland, Pa. Park J. L. Davis Funeral Home 12525 Bradbury Ave Smithsburg, MD 21. Signature of Funeral Service Licensee 23a. Party Errer the til ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The to (or as a consequence of) Physician/Medical Examiner burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician the as IF FEMALE: for use 23c. If yes, outcome pf pregnincy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autonsy performed yes 2 V Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Manner of Peach Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To After this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Fune completely f (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 Name and address of person who completed cause of death (Item 23a) (Type, Print) Sume 12 When MAR 1 4 Year) State [′] 2007 Registrar

Maryland 21215-0036

Baltimore.

			1- State of Maryland / Department of Health and Certificate of Death		2007	08029
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
Н	Physicia		CLAUDE RICARDO HAMILTON	MARCH	Day Year 7. 2007	7:15 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De		4c. County of Death	J.A. I.J. AM
			CHARLOTTE HALL VETERANS HOME CHARLOTTE HA		ST. MAR	Y'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours Mi	in. (Month, Da)		place (State or Foreign ntry)
	Director		216-30-2780 Talk 2 F 70 Yrs. Usual Residence of Decedent	AUG.13	3,1936 WAS	H.,DC
	ow #		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary First	tor	MARYLAND CHARLES LA PLATA			1XXes 2 □ No
	or 28g	lrec	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	ntry?
	or death with the Marylan terna 23e or 28a-f show sermust be notified at	Funeral Director	118 HAWTHORNE GREENE CIRCLE 20646		U.S.A.	
	tama	unel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ameri Black, White,	
36	rs afte	by F	1 □ Never Married XXMarried 1 ▼ Yes 2 □ No 1 ▼ Yes Sive AIR FOR CE 1 □ Yes XXNo Specify: Year of Dates.		Specify: WH	ITE
21215-0036	within 72 hours atter death with the Maryland iene. r than "natural", or Itame 23a or 28a-1 show the Masilcal Exah act must be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	dustry
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yla	Men Marke Marke Marke	10	LLOYD HAMILTON ALVER		ERSON	
Maryland	12 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or JOY HAMILTON-WIFE 118 HAWTHORNE GRE.			
-	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date CIRC	20c. Location - City or T	
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Baltimore	artm orta		21. Signature of Fureral Service Licensee / MO 0479 22. Name and Address of Facility			MAKTBAND
ä	Depa Impo any is	d i	RAYMOND FUNER.		•	
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	diac or respiratory at	7651,40	Approximate Interval Between
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	/Medical Examiner		Due to (or as a consequence of):			1-13
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9			IF FEMALE:			
Вох	leath certifica attending pl	lan/l	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
0	the a	Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
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ds,	uires signe	d by	Anemia	1 🗆 Y	res 2 □ No 3 □ Pro	bably 4 Unknown
Vital Records,	w require been signature should b	ompleted	hyperlipidemia	24a. Was		opsy findings available
Re	0 - 0	omp	- Sportipi Contra	 autop perfor 1 ☐ Yes 	rmed? death?	empletion of cause of
ital	sician: Th certificate irector, pag	e C	25. Was case referred to medical 26. Place of D	Death (Check only o		25110
of V	diis	To B		g Home 5□Resid	lence 6 Other (Speci	fy)
	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe h	now injury occurred	
Sio	Attending ir death. ector: After by the fune	cat	2 Accident investigation M 1 Yes 2 No	296 Logation /6	Street and Number or Rur	of Courts Alumbia
Division	al or Attence after death Director: d in by the	Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow		ar noute Namber,
_	lospital hours a uneral E		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ace, and due to the	cause(s) and manner as	stated.
	To the Hospital or a within 24 hours after within 24 hours after To the Funeral Directoropletely filled in b	edical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ccurred at the time,	date and place, and due t	o the cause(s)
	To the To the Comp	ğ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month,	Day, Year)
)			Jane Samon D45092		3/07/2	2007
	1+1		Name and narrows of person who of mpleted cause of death (Item 23a) (Type, Print) 110 Hospital Road Suite # 205 Prince f	Trade.	1. 0.0	20170
	Sta	to.	31. Date filed (Month, Day, Year) Registrar's Signature	· rear	CK, IND	206/8
	Registr		31. Date filed (Month, Day, Year) MAR 1 4 2007 MAR 2 4 2007			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	otate of marytan		rtificate of L			ı. No.	
Ė			Decedent's Name (First, Middle, Last	1)				2. Date of Death		3. Time of Death
	Physici /Medic		Jacqueline	L. Hickco	X			February	^{Day} 26, 200	7 4:15 A M
	Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of De	
			7050 Albany Avenu				Beach		Anne Ar	
H	Funeral Director		220 34 0703	ex	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 3/26/194	(9ar) 9. 8 Wa:	inthplace (State or Foreign Country) shington, DC
	nyland how		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Ba-1-	cto	Maryland Anne Art	ındel	N	orth Beac	h			1 ☐ Yes 2 ☑ No
	th with th	Funeral Directo	10e. Street and Number 7050 Albany Aven	ue		10f. Zip Code 20714		10	g. Citizen of What (USA	Country?
	ems T	Iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
020	ours afte rel', or it Exemin	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ XNo			Specify:	White
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3	Hyg other	BeC	17. Father's Name (First, Middle, Last)			.igne bupe		e (First, Middle, Ma		
Jana	uld be Aenta rked tic ev	To B	John Presto	n Hook				Ellen	L. Buck	
Mary	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!, or Items 23s or 28s-f show enty fourty or other traumatic event, the Medical Engineer must be notified at ance.		19a. Informant's Name/Relationship (Douglas L. Hickco			ng Address (Street a				
e e	of Head		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		lace of Disponentery, cre	osition (Name of matory or other place	se)	Date 2	Oc. Location - City	or Town, State
Ē	Peg ment tant: I		4 ☐ Donation 5 ☐ Other (Specify	v) Ka		rematory	2-27		Edgewater	
pairimor	Dependent Dependent Important Import		21. Signature of Funeral Service Licen	590				_		eral Home
			23a. Part1. Enter the disease, or com	plications that caused the deat		2973 Solor			-	Approximate
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	111		-		м,	Interval Between Onset and Death
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	Examiner		Sequentially list conditions	b						
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
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0.00	death	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	delivery Day Year
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coras	equire en sig ould bu							1 🗀 Yes	2 5 № 3 □	Probably 4 Unknown
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VISION	inding ath. r: Aite	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Worl	k? Yes 2 □ No		,,	
<u> </u>	or Atte	Certification:	3 Suicide 6 Could not be determined		ome, farm, st	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours eiter death. To the Funeral Director: Atter this certificate he completaly filled in by the funeral director, page	edical Ce	(Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina	wledge, dea	th occurred at the tin	ne, date and place, pinion, death occur	and due to the cau	use(s) and manner e and place, and d	as stated. ue to the cause(s)
	o the ithin 2 o the omplei	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens			d. Date signed (Mo	
	F 3 F 8		1 Clanist	vous on		1219	di Xa	MO	26 Fet	307
	10		30. Name and address of person who	completed cause of death (Item	n 23a) (Type	Print)	l.	(211)		7 31
	10	10	31. Date filed (Month, Day, Year)	32. Agistrar's Signa	UY.	MANA	your	1010	2140	, Jen DLines
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		•	For State Registrar	State	of Marylan		artment <i>rtificate</i>			Mental Hyو ا	giene Reg. No.	007	08031
			1. Decedent's Name (First, Middle,	Last)						2. Date of Dea		Veet	3. Time of Death
	Physici /Medic		Michael Thomas	s Hagan						Februar	y 25	, 2007	5:05 A M
	Examin		4a. Facility Name (If not institution,	-	ımber)				cation of Deat	1		County of Death	
			416 Dutch Driv		T			thia		1		Anne Ar	
	Funeral			6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months		f Under 24 Hrs. Hours Min.	(Month, Day	y, Year)	Col	place (State or Foreign intry)
ш	Director		212-14-5889 Usual Residence of Decedent		81	710.				9/25/	1925	wası	nington, DC
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
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	or 28	lre	10e. Street and Number				10f. Zip C	Code			10g. Citiz	en of What Co	intry?
	238	le l	416 Dutch Drive					20711		-		US	
	er de	Funeral Director	11. Marital Status	Armed F	cedent Ever in U orces?	.S. 13.	Was Decede If Yes, specif	nt of Hisp y Cuban,	anic Origin? (S Mexican, Puerl	pecify Yes or No- o Rican, etc.)	. 1	 Race - Amer Black, White 	
5	rs aft	by F	1 ☐ Never Married 2(1) Marrie 3 ☐ Widowed 4 ☐ Divorced	od 1 K) Yes If Yes, G	2□No live Dates:1942-	-46	1 ☐ Yes 2	M∑No .	Specify:			Specify: L	hite
212-0030	2 hou		15. Decedent	s Education		16a, Dece	dent's Usual	Occupation	on =		16b. Kin	nd of Business/l	
2	hin 72	Completed	(Specify only highes Elementary/Secondary (0-12)	T	(1-4or 5+)	(Give	kind of work DO NOT use	done dur retired)	ing most of wo	rking			
7	gien th	no.	12th	00,100	(. 40, 01)	Rea1	Estate	e App	raiser		F	Real Es	tate
/land	a Hy d oth	Be (17. Father's Name (First, Middle, L					11		ne (First, Middle,		Sumame)	
<u>X</u>	Ment Ment arke	ဥ	Peter J.	Hagan					Mary	Gerhard	t		
Mar	and i and i		19a. Informant's Name/Relationsh							iral Route Numbe			ip Code)
e,	Health		Rita D. Hagan/ 20a. Method of Disposition	wile	20b. F				re, Loti	nian, MD		L I cation - City or "	Town State
<u></u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 ie marked other than "natural", or items 23s or 28s-f show styl fighty or other traumatic event, the Madical Examinar must be nutilled at an ance.		1 ☐ Burial 2 X Cremation		Joiale	Place of Dispo cemetery, crer alas Cr			2-26			gewater	
Saltimor	artme ortan Injury		4 □Donation 5 □Other (Sp 21. Signature of Funeral Service L		Ke			•		orge P.	•	-	•
ä	Depa impo eny l		> Mount All	1/						ind Rd. I			
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the deal								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- 1	eno Corc	212000	10 6	1 +1	/ ,	ung			Pour Monty
	/Medical		resulting in death)		o (or as a consec			0	W M	0			1001 101
	Examiner		Sequentially list conditions	ь									
	st ad	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a consec	quence of):							
	and and il-tran	хап	that initiated events resulting in death) Last	c. Due to	o (or as a consec	tuence of):						-	
2/60	icate be executed physiclan and s the burial-transit	calE											
ρ	ificate g phy: as the	ed		0.									
XOD	the death certifi y the attending Iched for use as	clan/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		75-4				2	3d. Date of deli	very
_	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ☐ Feta gnant at time of c]Ectopic pre] Other (spe	gnancy cify)				Month	Day Year
J.	at the by the	Phys	9 🗆 Unknown	1									
<u>က်</u>	law requires that the death certific as been signed by the attending p 2 should be detached for use as	þ	Part II. Other significant conditio	ns contributing to	death but not res	sulting in the u	nderlying ca	use given	in Part I.				the cause of death?
Records,	requi	Completed								1,24,1	/es 2 [100 3 P	obably 4 □Unknown
ဍ	elaw hast	nple.								24a. Was autop		prior to o	topsy findings available ompletion of cause of
	sician: The law s certificate has t lirector, page 2 s									1 ☐ Yes	2 0 No	death?	2 🗆 No
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:	7	150/0		Other		ath (Check only o			
Ö	Phy this ral d	l⊫ i	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date	e of Injury	ER/Outpatier 28b. Time o		c. Injury a	4 Nursing F	lome 5 X Resid			eify)
0	ttending Physician: Jeath. tor: After this certific the funeral director,	atlon:	1 SNatural 5 ☐ Pending 2 ☐ Accident investig	,	nth, Day Year)	Injury	м	Work?	s 2□No				
Division	ar deg	ertificati	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 288. Plac	ce of Injury - At h	ome, farm, sti	reet, factory,	office		28f. Location (S City or Tox	Street and	d Number or Ru	ral Route Number,
5	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	O		Dull	g, atc. (apaci					Only of 700	, State)		
	Hospi 4 hou Funer ely fill	edical	(Check only 2 Medical I	g Physicien: To the xaminer: On the	basis of examina	owledge, deat ation and/or in	h occurred a	t the time, in my opin	date and place	and due to the urred at the time,	cause(s)	and manner as	stated. to the cause(s)
	To the within 2. To the complet	Med	one) 29b. Signature and title of certifier	and ma	nner stated.								
	8 1 2 1		D. C.	0 3	who	_,mp		724	2563	1	-	(40 -)	(. 2007
			30. Name and address of person	who completed as	use of death (lea-	m 23a) (Type	Print)	י כ כ	J 4-	1	000	10 Q	-1
	7+1			3íciba		D 1	34 0	Wer	150/16	e Road	, W.	ost Piv	(2007.
	Sta		31. Date filed (Month, Day, Year)	32.	egistrar's Sign	atura	mod 8	c					
345	Registi	rar	FFR 2	7 7007 4		15 14	66						

Physician /Medical Examiner

death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show must be notified at

ō 23a

items

Hospital or Attending Physician: The law requires that the death certificate be executed physician this After 1 o 24 hours after death.

The Funeral Director: Af the funderely filled in by the funderely filled in b

Division or Vital Records, P.O. Box 68760,

examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00062955

Medical To the Fune

Registrar

Certification: To

COURTNEY FITZHUGH 31. Date filed (Month

10 CENTER DRIVE, BETHESDA, MARYLAND 20892 32. Registrar's agnatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

0

30. Name and address of person who

31. Date filed (Month, Day, Year)

MAR 01 2007

completed cause of death (Item 23a) (Type_Print)

32. Registrar's Signature

			For State Registrar	State of Marylan		tificate of			giene Reg. No.	2007	08031	
ï	Physici		1. Decedent's Name (First, Middle, Last) Earnestine L.					2. Date of De Month Februar	Day	Year 2007	3. Time of Death 22:24P M	
- F	/Medic		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Dea			County of Death		
	LAGIIII	161	Southern Mary	land Hospital			Clinton			Prince	George's	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birthi	place (State or Foreign	
U	Director		437-62-2839	M 21XF 65	Yrs.	Months Days	Hours Min	. (Month, Da		Coui	ntry) uisiana	
-9%	D		Usual Residence of Decedent					Whi 4	174.	1 1101	IISTAIIA	
	rylan how	١.	10a. State 10b. County	10c. City	y, Town or Lo	cation				'	10d. Inside City Limits	
	a-f s	恴	Maryland Prince G	eorge's		Temp1	e Hills				1∭Yes 2 No	
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	ntry?	
	th wi	a l	4218 Beach Craf	t Court			20748		U1	nited St	tates	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of I	Hispanic Origin? (S	Specify Yes or No)- 1·	 Race - Americ Black, White, 		
9	after or ite	E	1 Never Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give	-	l⊡Yes 2⊠ No		no moun, oro.,		Afi	rican	
<u></u>	iai";	d by	3 ☐ Widowed 4 ★ Divorced	Year or Dates:		220110	орсону.		. '	Specify: Ame	erican	
2	72 h 'natu dical	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced (Give	lent's Usual Occu kind of work done	pation during most of wo d)	orking	16b. Kin	d of Business/In	dustry	
7	rithin ne. han '	Ig I	Elementary/Secondary (0-12)	College (1-4or 5+)								
Ŋ	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Ex miner must be notified at		47 Fatharia Marra /Fires Adiabile 1 and)	2	Di	etary Sp	ecialist		14-14	Private	2	
anc	be fi	a	17. Father's Name (First, Middle, Last)	1 4 0			18. Mothers Na	me (First, Middle		,		
<u>X</u>	should be filed vand Mental Hygies marked other tumatic event, th	은	Fester Fra		1				C. Le			
Maryland 21215-0036	~ @		19a. Informant's Name/Relationship (Ty	•	19b. Mailin	ig Address (Stree	and Number or R	lural Route Numb	er, City or	Town, State, Zip	code)	
	1 and 1 Health em 27 other tra		Livia J. Hall/Da	ughter	43	13 Lakev	iew Dr.,				20748	
Baltimore,	Pages 1 nent of H ant: If iter ury or oth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ R		lace of Dispo emetery, cren	sition (Name of natory or other pla	ice)	Date	20c. Loc	ation - City or To	own, State	
Ē	Pag meni ant: lury	1 2	4 ☐ Donation 5 ☐ Other (Specify)	la-			Park 3/3			Landover	, MD	
a	permit. Page Department of important: If any injury or once,		21. Signature of Funeral Service Licens	#	/ 22	. Name and Addre	ess of Facility S	tewart F	unera	1 Home		
<u> </u>	20 E # 9		15m 1. 2	(ewar) III	/ 1		Benning			1., DC	20019	
Г			23a. Part1. Enter the disease, or compli shock, pr∖heart failure. List only or	cations that caused the death	n. Do not ente	er the mode of dy	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician	ă V	Immediate C. u. e (Finai disease or condition	ACUTE MYO							Onset and Death	
1	/Medical		resulting in death)	Due to (or as a consequ			1 (100 (10)					
b	Examiner		Parameter and the second	CORONAR	4 ART	TERY D.	SEASE					
		ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ								
	cuted Id ransi	Examiner	Cause (Disease or injury that initiated events									
o Ô	tificate be executed g physician and as the burial-transit	Ě	Sesuring in death) Last Due to (or as a consequence of):									
68760,	te be ysicia ne bu	edical		l								
89										1		
Box	The law requires that the death cer tte has been signed by the attendir tage 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregna 1□Live birth 2□Fetal		Ectopic pregnanc			23	3d. Date of delive	ery	
	deat e att	icis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		Other (specify) _	у			Month	Day Year	
Ö	t the by th tache	hys	9 Unknown	9□Unknown								
ις.	ned e de	by P	Part II. Other significant conditions con		ulting in the ur	nderlying cause gi	ven in Part I.	23e. Did t	obacco us	e contribute to t	he cause of death?	
Ö	quire n sig uld b	<u>8</u>	HYPERTENSI	cN				10	Yes 2□	No 3☐ Prol	bably 4X Unknown	
ပ္ပ	sw re s bee	Completed						24a. Was	an	24b. Were auto	opsy findings available	
Re	he la e has	Щ							ormed?	death?	opsy findings available ompletion of cause of	
Vital Records, P.O			25. Was case referred to medical		<u> </u>		OF Place of De	1 Yes	2 🗐 No	1 □ Yes	2□ No	
	Attending Physician: The law r death. ector; After this certificate has bey the funeral director, page 2 s	o Be	examiner?	lospital: 1 ☐ Inpatient 2 🔄	ER/Outpatien	t 3 DOA Oti	ner:	eath (Check only o		Пон (д :		
ō	<u>a</u> = <u>a</u>	-: 1	27. Manner of Death	28a. Date of Injury	28b. Time of	1 3 DOA	4 Li Nursing	Home 5 ☐ Resi 28d. Describe			<i>y)</i>	
on	ttending leath. tor: After the funer	tion	1 ☑Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2 □ No		,,			
S	or Attending after death. Director: After in by the funer	ica	3 Suicide 6 Could not be	28e. Place of injury - At ho	me. farm. stre			28f. Location (Street and	Number or Run	al Route Number,	
Division or	i or At after d Direct I in by	Certification:	4 ☐ Homicide determined	building, etc. (Specif)	y)	- · · · · · · · · · · · · · · · · · · ·		City or To	wn, State)	77277201 01 71270	ar riodic rearribor,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in 1		29a. Certifier 1 Certifying Phys	sician: To the best of my know	wledge, death	occurred at the t	ime, date and plac	e, and due to the	cause(s)	and manner as s	stated.	
	24 h	Medical	(Check only 2 Medical Exami	ner: On the basis of examinat	tion and/or in	vestigation, in my	opinion, death occ	curred at the time,	date and	place, and due t	o the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier	and married states.		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)	
	⊢≯⊢ŏ		JOORIC			Dy	10324			VARY 23		
/					00a) (T =					1 93	,,,,,,,	
1/4	(5)		30. Name and address of person who co				, CLINT	on, MAR	MLAN	D		

31. Date filed (Month Day Year) FEB 2 8 2007 State Registrar

32. Registrar's Signature

			For State Registrar	State of Maryland /		artment of H			iene _{eg. No.}	07	080	35
п	Dhysisi	an l	1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	th Day	Year	3. Time of D	
	Physicia /Medic		Ruth	E		Harper		Februar	y 25	,2007	7:00	A M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	r Location of Death			nty of Death		
			Millennium- Ft				ashingt				eorges	
	Funeral		Social Security Number 6. S	Du Xos	irthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year)		place (State or	Foreign
	Director	ŀ	579-42-2113 Usual Residence of Decedent	105	113.			10/05/	1901	Mar	yland	
	land ow		10- Ct-t- 10h Courts	cince 10c. City, To	wn or Lo	cation				1	10d. Inside City	Limits
	Many f sh	ŏ	Maryland Geom		La	rqo					1X Yes	2 □ No
	1 the	rec	10e. Street and Number	ges		10f. Zip Code		1	0g. Citizen	of What Coul	ntry?	
	38 o	D E	500 N Harry Tri	man Drive Ant	304	2	0774		119	SA		
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. F	lace · Americ		
ထွ	after or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X No		1 □ Yes 2 No	Specify:	riioari, etc.)	Spe		etc.	
9	72 hours after death with the Maryland natural; or Items 23a or 28e-f show deat Exemitter must be mutified at	d by	3X Widowed 4 ☐ Divorced	Year or Dates:		12,10				BT	ack	
21215-0036	"natu	Completed	15. Decedent's E- (Specify only highest gra		(Give	dent's Usual Occup kind of work done	during most of work	king	16b. Kind of	Business/In	dustry	
12	withir	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	1)		Dor	nesti	C	
	be filed within 72 hours after death with the Marylan ital Hygiene. od other then "natural", or Items 23a or 28e-f show event, Ite Madical Examilian matter matter molified at	ပိ	12 17. Father's Name (First, Middle, Last,		Ca	retaker	18. Mother's Nam	e (First, Middle,				
an	Mental Mental arked o	To Be	Richard	_	row	n	Joanne			Nπ	iddlet	- 0 10
Maryland	ges 1 and 2 should be it of Health and Mental : If item 27 is marked o or other traumatic eve	-	19a. Informant's Name/Relationship (and Number or Rus	ral Route Number	, City or Tov			.011
	1 and 2 Health a tem 27 is		Ruth Turner / Da	ughter 3	685	Towa Ro	oad Brai	ndvwine	Mar	ylan	d 2061	3
J.	of Her		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of natory or other place	1			on - City or To	own, State	
Ĕ	Pages nent of I ant: If its ary or o		Marial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		inal	ham Myer	rs 03/0	03/07	Upper	Mar	lboro,	MD
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fyneral Service Lice		22	. Name and Addre	ss of Facility Ada	ams Fun	eral	Home	PA	
	20 5 2 3		Flyk E	15/	21	0605 Aq1	<u>uasco Ro</u>	d Aquas	co, N	[aryl	and 20	608
г			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do one cause on each line.	not ent	er the mode of dyin	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Betwo Onset and De	een
100	Pnysician	8.7	Immediate Cause (Final disease or condition	a.Myocardial I	nfa	rction					hours	
	/Medical Examiner		resulting in death)	Due to (or as a consequence								
l.		<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Arterioscler	oti	ccardio	vascula	r disea	se		years	5
	nted I Insit	min.	Cause (Disease or injury	c Hypertension							years	
Ć.	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	∍ of):						ycari	,
8760,	ysicia e bur			_ d								
9	tifical g ph as th	ledi							1000			
Вох	death certific e attending p d for use as 1	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3	Ectopic pregnancy	,			Date of delive	•	
	deat he att	Physician/Medical	in the past 12 months? 1 Pyes 2 PNo	4☐Pregnant at time of death 9☐Unknown		Other (specify)				Month	Day Ye	∋ar
P.0	that the de led by the a detached t	Phy	9 Unknown					an- Dida-				-450
S,	ires tha signed d be de	by	Part II. Other significant conditions of	contributing to death but not resulting	in the ui	nderlying cause giv	en in Part I.		es 2X No		he cause of de cably 4 ⊟Ur	
orc	law requires as been sign 2 should be	eted	Pneumonia									
Vital Records,	elaw has b	Completed	Cerebrovascu	ılar Accident				24a. Was a autops perfori	SV	b. Were auto prior to co death?	ppsy findings a impletion of car	allable use of
a	i: The icate ha							1 Yes	2X No	1 ☐ Yes	2 🔀 No	
VIE VIE	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	er _	th (Check only or				
of	Physician: this certific ral director,	To.	1 ☐ Yes 🌠 No 27. Manner of Death	1 Inpatient 2 EH/C	utpatien Time of	IT 3LIDUA	4 Nursing H	ome 5 Residence 28d. Describe he			(y)	
ou	tending Physician: leath. tor: After this certific the funeral director,	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No		,,			
Division		fica	3 Suicide 6 Could not b	e 28e. Place of Injury - At home,	farm, str	eet, factory, office		28f. Location (S		mber or Run	al Route Numb	er,
á	al or A after I Direct d in by	Certification:	4 Homicide	building, etc. (Specify)				City or Town	n, State)			
	e Hospital 24 hours a Funeral letely filled			nysicien: To the best of my knowled								
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	ledical	one)	niner: On the basis of examination a and manner stated.	mayor in							
	Vith To	Σ	29b. Signature and title of certifier	8 +		29c. Licens	e number	2	ed. Date sig	ned (Month,	uay, rear)	
F ,			dora	Skengler		D32	800		Feb.	27,	2007	
(DRZ		30. Name and address of person who) 3 # O	٥		_ h	
	Sta	ite	H. Herbert Wash 31. Date filed (Month, Day, Year)	32. Refistrar's Signature			ngston I	koad# 2	US Ft	. Wa	sningt	.on
	Registr		FEB 2 8	2007 Merene B	6	book				Md :	20744	

DHMH 17 Rev 1/2001

For	State of Maryland / Department of Health and M	Mental Hygiene	00000
State Registrar	Certificate of Death	Reg. No.	06036
Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death

Physici /Medi Examir

Funeral Director

Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1 - State Registrar		Cert	ificate of L	Death	Re	eg. No. 💪 🔾		00000		
	1. Decedent's Name (First, Middle, Last)					2. Date of Deat			3. Time of Death		
an	Josephine Frances	Herlihy				Februar	y 26,	2007	9:20 P M		
eal ier	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Deat		4c. County				
ici	Casey House			Rockvill		D. D. J. of Birth	Montg		(2)		
	5. Social Security Number 6. Sec. 190–20–4675	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		1930	Coun	lace (State or Foreign try) sylvania		
	Usual Residence of Decedent	100 City	, Town or Loca	tion				14	0d. Inside City Limits		
h	10a. State 10b. County	Toc. City	, TOWIT OF LOCA	luori				"			
5	MD Montgomer	y Mon	tgomery	Village			_		1 ☐ Yes 2 ☐ No		
Funeral Director	10e. Street and Number 19305 Club House R	oad #104		10f. Zip Code 20886			0g. Citizen of ' SA	What Coun	try?		
Jerg	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. W	as Decedent of His	spanic Origin? (S	Specify Yes or No- to Rican, etc.)		ce - America			
by Fur	1 Never Married 2 Married 3 Widowed W Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		res, specify Cubai ⊐Yes 2X No	n, mexican, Puer Specify:	to Hican, etc.)	Specif	ck, White, e			
Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a. Decede (Give ki	nt's Usual Occupa nd of work done do NOT use retired)	ition uring most of wo	rking I	16b. Kind of B				
큩	Elementary/Secondary (0-12)	College (1-4or 5+)		_	_	- 1	Orm Ha	m.a			
Ö			Homema				Own Hor				
Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, I	Maiden Surnar	ne)			
은	Joseph Frisina					Brescion					
	19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street a	nd Number or Ri	ural Route Number	, City or Town	, State, Zip	Code)		
	Laura Beth Pohopin			Pines T		arker, CO					
	20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ R	temoval irom State		tion (Name of atory or other place	!		20c. Location - City or Town, State Beltsville. MD				
	4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licens	- One:	sapeake	Cremato	${ m ry} \pm 02/2$ s of Eacility	28/07 B	eltsvi.	lle. I	MD		
ļ			31.55	_		on Servic					
	23a. Part1. Enter the disease, or compli	ications that caused the death						VILLE,	MD 21029 Approximate		
	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		,	,	, , ,			Interval Between Onset and Death		
	disease or condition resulting in death)	a. Chronic Obst Due to (or as a consequ		e Pulmon	ary Disc	ase		-			
		200 to (0.00000000000000000000000000000000000									
iner	Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):								
/Medical Examiner	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):								
calE		d									
ledi											
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna		iotonio prognancii			23d. Da	ate of delive	ery		
Physiciar	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	1∐Live birth 2 ☐ Fetal 4☐ Pregnant at time of de 9☐ Unknown		ctopic pregnancy Other (s <i>pecify)</i>			Me	onth	Day Year		
Ph	Part II. Other significant conditions con	ntributing to death but not resu	alting in the und	erlving cause give	n in Part I.	23e. Did tol	pacco use con	tribute to th	ne cause of death?		
Completed by						1 🛣 Y∈			ably 4 □Unknown		
plete						24a. Was a		Were auto	psy findings available		
E O						autops perfori 1∐ Yes	ned?	death?	πριετιοπ or cause or 2□ No		
Be (25. Was case referred to medical examiner?					ath (Check only on	e)				
P	1 ☐ Yes ZX No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3 DOA Othe	r: 4 🗆 Nursing I	Home 5□ Reside	ence 6 🛚Otl	her <i>(Specif</i>)	hospice		
	27. Manner of Death 1X☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ \	at ? ∕es 2 □ No	28d. Describe ho	ow injury occur	rred			
ifica	3 Suicide 6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify			_	28f. Location (Si City or Town	Street and Number or Rural Route Number,				
1 400			,			2, 5	, 2.2.0)				
Cer						1					
dical Cer		sician: To the best of my known iner: On the basis of examination and manner stated.									
Medical Certification:	(Check only 2 Medical Exami	iner: On the basis of examinat			oinion, death occ	curred at the time, d	late and place	, and due to	the cause(s)		



State Registrar 31. Date filed (Month, Day, Year) MAR 0 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Williams, D.O. 6001 Muncaster Mill Rd. Rockville, MD 20855 32. Resistrar's Signature berle

		4	For State	State	of Marylan		rtment o			lental Hygi		007	00027
			Registrar 1. Decedent's Name (First, Middl	e. Last)		Cer		Dear	,, 	2. Date of Deat	eg. No.		3. Time of Death
	Physicia /Medic	_	Glen Hazlehurst							Februar	$y \stackrel{\text{Day}}{2} 7$,	2007	6:20 P M
	Examin	er '	4a. Facility Name (If not institution	n, give street and no	ımber)		4b. City, Tow		on of Death			nty of Death	
			Casey House 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	Rockvi		der 24 Hrs.	Date of Birth		gomery 9. Birtho	lace (State or Foreign
	Funeral Director	- 1	143–18–3918	1□ M 2X F		82 Yrs.	Months Da		s Min.	8. Date of Birth (Month, Day, June 4,	1924	Mary.	land
	D.	- h	Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
	faryla shov ed at					thersb							1 □Yes 2X No
	the N	rect	MD Montgo	мету	Gai	CHELSD	10f, Zip Co	le		11	0g. Citizen o	of What Cour	ntry?
	h with 23a or st be	al Di	11505 Piney Loc	lge Road			20878			U	SA		
	r deat	Funeral Director	11. Marital Status	Armed F	cedent Ever in U	l.S. 13. \	Was Decedent f Yes, specify	of Hispanic Cuban, Mexi	Origin? (Spe ican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,	
30	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🛣 Divorced	If Yes. G			1□Yes 🛣	No <i>Sp</i> ec	ify:		Spe	cify: Whi	te
9500-612	2 hou natura ical E		15. Deceder	nt's Education est grade completed	0	16a. Deced	tent's Usual O	cupation	nast of work	ina	16b. Kind of	Business/Inc	dustry
Z	e filed within 72 h al Hygiene. I other than "natu vent, the Medica	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	1	kind of work d DO NOT use re			1	Fodors	al Corr	ernment
2	iled w Hygier Iher th		17. Father's Name (First, Middle	5+		Admith	<u>istrato</u>		ogram other's Name	e (First, Middle, I			ernment
yland	d be f ental b ked ol c evel	To Be	Charles Hazleh	•					el Gle			,	
=	es 1 and 2 should be fi of Health and Mental H f Item 27 is marked otl r other traumatic ever	Ε.	19a. Informant's Name/Relation Andrew Winters/	ship (Type. Print)						al Route Number Gaithers			
Baltimore,	Pages 1 and 2 nent of Health a ant: If Item 27 is ury or other trai		20a. Method of Disposition 1 Burial 2 Cremation		n State	Place of Dispo cemetery, crei	matory or othe	place)	03/01	1		ille,	
	permit. Page Department o Important: If any injury or once,	i	4 □ Donation 5 □ Other (21. Signarule of Funeral Service		one	_				on Servi			
ñ	Dep Imp any		1 (2) welly I	Horris		1251 B	everly	L. He	ckrott	te, P.A.	Clarl	ksvill	e, MD 21029
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that tonly one cause on	t caused the dea each line.	th. Do not ent	ter the mode o	dying, such	as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		stic Ane								
	/Medical Examiner		roodaling in abdaily	Due t	o (or as a conse	quence of):							
b	GIAM.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due t	o (or as a conse	quence of):							
	ecuted nd transit	Examine	Cause (Disease of injury that initiated events resulting in death) Last	c									
8760,	ficate be executed physician and s the burial-transit	E E	resulting in death) Last	Due t	o (or as a conse	quence or):							
687	ficate g phys s the	edical		d									
ŏ	leath certific attending p	M/us	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregr		⊒Ectopic pregi	ancv				Date of deliv	•
П	ie deal the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown		gnant at time of		Other (speci					Month	Day Year
<u>а</u>	w requires that the deben signed by the should be detached	Phy	Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	inderlying caus	e given in P	art I.	23e. Did to	bacco use c	ontribute to t	the cause of death?
rds,	quires n sign	d by								1 🗆 Y	es 2□N	o 3 🗆 Pro	bably 4 Nunknown
S S S	aw rec is beei 2 shou	Completed								24a. Was a		b. Were auto	opsy findings available ompletion of cause of
ž	Physician: The law this certificate has trail director, page 2 s	mo:								perfor	med? 2 4No	death?	2 □ No
/ita	iclan: sertific setor,	Be	25. Was case referred to medic examiner?	al Hospital:				045		th (Check only or			
or	Physic ruthis cral dire	7	1 Yes 2 No	11	Inpatient 2	ER/Outpatie		Injury at Work?	Nursing H	ome 5 Resid			hospice
O	nding Fith.	tion	1X Natural 5 ☐ Pend	/8.4	onth, Day Year)	Injury	м	Work? 1 ☐ Yes	2 □ No				
Division or Vital Records, P.O. Box	r Atter er dea rector	Certification:	3 Suicide 6 ☐ Could	mined 289. Pla	ice of injury - At i		reet, factory, o	fice		28f. Location (S City or Tow	treet and Nu	ımber or Rur	al Route Number,
Ō	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		One Contilled at 137 on the	ing Physician: To			th occurred of	ha timo del	to and place	and due to the	calleg(e) and	l manner co	etated
	P Hosp 24 ho Fune etely f	Medical		al Examiner: On the									
	To the within To the Comple	Me	29b. Signature and title of certif			_		cense numb		:		gned (Month	
			Kynchia	n spil	leomo	DO	H	00580	032		ノーン	27-20	007
3	02		30. Name and address of person Cynthia M. Wil	n who completed ca liams, D.	ouse of death (Ite	em 23a) (Type Muncas	Print)	ll Rd.	Rock	ville, M	D 208	55	
	St Regist		31. Date filed (Month, Day, Yea	1 2007 A	egistrar's Sig	nature	parte						

	1	For State		State of N	Marylan		epartmo C <i>ertific</i>				_	_	0000		00000
		Registrar 1. Decedent's Name	(First, Middle, La	st)			,	210 01 1	Doan	1	2. Date of De	Reg. No. ath	200	3	3. Time of Death
Physician /Medical		Kather		,	H	towa	ivd				Month OR	Day 28	Year		0930 M
Examiner		4a Facility Name (If	not institution, giv	at the L	er) AKE Age (In yrs. I	lact hirth	S	ity, Town, or	ury	of Death	8. Date of Bir	14	County of Dea	00	o (State or Foreign
Funeral Director		214 10 77		_M 2XF		7/ Y	Mont		Hours		(Month, Da	y, Year) 19		ountry)	e (State or Foreign and
pun M		Usual Residence of 10a. State	Decedent 10b. County		10c. City	/. Town o	or Location			•				10d.	Inside City Limits
Maryle f sho		MD	Wicomic	0			sbury								1 Yes 2 No
vith the Mar or 28a-f sl be notified	2	10e. Street and Nun						Zip Code				10g. Citi	zen of What C	ountry?	?
th with	ב ב	511 Buen	a Vista	Avenue				2	21804	+			US	SA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "hatural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Dy ruile	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed	_	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Dates	s? No	S.		ecedent of H specify Cub: s 2 No	lispanic C an, Mexic Specif		cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi Specify:		
2 hourantura	2	/Cnac	15. Decedent's E			16a. D	ecedent's l	Jsual Occup	ation	ant of working	20	16b. Ki	nd of Business	s/indust	try
ed within 72 horygiene.	- 1	Elementary/Secon	ify only highest grand	College (1-4c	or 5+)		Give kind of life. DO NO Homema		during mo d)	ost of workir	ng	Owi	n Home		
filed v Hygic Sther i the sent, the		17. Father's Name (First, Middle, Last	none		l	пошеш	akei	18. Moti	her's Name	(First, Middle				
Mental H arked ott		Ernest	H. Riggi	n					Nor	a Smu	llen				
2 shot and h is ma		19a. Informant's Na	me/Relationship (Type. Print)		19b. I	Mailing Add	ess (Street	and Num	ber or Rura	l Route Numb	er, City o	r Town, State,	Zip Co	ode)
1 and Health Health ther tr	Ì	Linda Wh	ite/Daug	hter	20h B		36 Mi		Mil1		oate Owin	gs M	ills, N	MD 2	21117
Pages nent of hint: If ite		1 Burial 2		Removal from Sta	te C	emetery,	, crematory	or other pla					ncess A		
permit. P Departme Importan any Injur	1	21 Signature of Fu		nsee	100295		22. Nam Hinma	and Addre	ess of Fac	Home					
	-	a. Part1. Enter th	ne disease, or com	plications that caus	sed the death	h. Do no							Anne,	Ar	poroximate
Physician	4	shock, or hear mmediate Cause (disease or condition	Final	one cause on each	n line.		0	CoM.	127 2 200					Ot	terval Between nset and Death
/Medical Examiner		resulting in death)	(a. Due to (or	as a consequ	uence of): / A	CO HH	41.19						
	<u>5</u>	Sequentially list cor if any, leading to im cause. Enter Unde	nditions, mediate	b. Due to (or	as a consequ	uence of	·):								
executed in and ial-transit		that initiated events resulting in death) L	injury	с											
cate be executed physician and the burial-transit	Ę.	resulting in death) t	Last	Due to (or	as a consequ	uence of):								
ifficate g phys as the	edicai			▲d		n jeden j						- 15			
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Pnysician/me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcor 1 ☐Live birth 4 ☐Pregnan 9 ☐ Unknown	n 2∐Feta tattime ofd	l death	3 □Ectop 5 □ Othe	ic pregnanc (specify) _	у				23d. Date of d Month	elivery Da	ay Year
s that the ned by a detact	Dy Fin	Part II. Other signif		contributing to deat	h but not res	ulting in	the underlyi	ng cause giv	ven in Par	rt I.	23e. Did	tobacco	use contribute	to the o	cause of death?
equire equire en sig ould b											1 🗆	Yes 2	No 3□1	Probab	ly 4 □Unknown
The law rate has be page 2 sh	Completed										24a. Was auto perf 1∐ Yes		prior to death?	compl	y findings available letion of cause of
certific ector,	De	25. Was case refer examiner?	/	Hospital:				Oth	ner.		(Check only			- (
Phys	2	1 Yes ≥ 27. Manner of reat	No h	28a. Date of I	Injury	ER/Outp 28b. Ti	me of	28c. Inju Wo	4 🗆 1		me 5 ☐ Res 28d. Describe		6 □Other (Sp ry occurred	ecify)	
ath.	ation	1 Natural 2 ☐ Accident	5 Pending investigation	4	Day Year)	lnj	jury M		rk?]Yes 2[□No					
I or Atte after des Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	20e. Flace of	injury - At ho , etc. <i>(Specif</i>	ome, fari fy)	m, street, fa	ctory, office			28f. Location City or To	Street ar wn, State	nd Number or I	Rurai R	Route Number,
Hospita 24 hours Funeral etely filled	Medical	29a. Certifier (Check only one)		hysician: To the be miner: On the basi and manner	is of examina										
To the vithin To the compl	Z	29b. Signature and	title of certifier	0/				29c. Licens	se numbe	er		29d. Da	te signed (Mo	nth, Da	ay, Year)
		()	15	00	M			Nã	76	278		2-	-28-	0	2
		30. Name and addr	Cough, K	W Crost	of Hoo	914	Type, Print)	x17.	33	501	Ish	N	D 2	180	52
State Registra		31. Date filed (Mon	MAR 0 5		israr's Signa	ature	1	all s				γ			

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DHMH 17 Rev 1/2001

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		·	For State Registrar	State of Ma		epartme C <i>ertifica</i>			and Me		ene (07	08040
12	454 . L		1. Decedent's Name (First, Middle, Las	t)						2. Date of Death Month	D	Vear	3. Time of Death
	Physici /Medic		Michael Wayne	l mes					F	ebruary	/ ^{Day}	2007	2:35P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Ci	ly, Town, or	Location of	of Death		4c. Cou	inty of Death	1
			Prince George's H					everl			Pr		eorges
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ax 7. Ag XIM 2□F	e (In yrs. last birth 58 Y	Month	ler 1 Year s Days	If Under: Hours	Min	Date of Birth (Month, Day, ept. 22,	1948	Cor	pplace (State or Foreign untry) y land
11	pu »		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location							10d. Inside City Limits
	ahov ahov	ក		: -1:	Too. Oity, Town		hurma	n.t				-	1 ☐ Yes 2 🛣 No
	28a-f	Director	Maryland Freder 10e, Street and Number	ICK			hurmo Zip Code	111		10	o Citizen	of What Cou	intry?
	with Sa or		12027 Pennterr	a Manor La	ane	75		1788			-	J.S.A.	, .
	death	Funeral	11. Marital Status	12. Was Decedent		13. Was De	cedent of H	ispanic Ori	gin? (Spec	fy Yes or No-	14.	Race - Amer	
õ	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow or other traumatic event, the Madical Examinal multila and or other traumatic event, the Madical Examinal multila and or other traumatic event, the Madical Examinal multila and or other traumatic event, the Madical Examinal multila and or other traumatic event, the Madical Examinal multila and or other traumatic event.	y Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	No		pecify Cuba 2 No	an, Mexican Specify:	i, Puerto Ri	ican, etc.)		Black, White	
ğ	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	100	Danada da		-1			ICh Kind a		hite
7	n 72 "nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		Decedent's U (Give kind of life. DO NO)	work done	during mos	t of working	7	166. Kina c	f Business/I	ndustry
7	with iene. than	E O	Elementary/Secondary (0-12)	College (1-4or 5	5+)	cable	spli	cer			com	munica	ation
0	illed Hygi other	BeC	17. Father's Name (First, Middle, Last)						er's Name (First, Middle, N	laiden Sur	name)	
<u>a</u>	Mental Mental arked o	To B	Ralph Ernest I	mes				Ве	ssie	June Sn	nith		
<u>a</u>	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (Гуре, Print)						Route Number,			
Baltimore, Maryland 21215-0036	is 1 and 2. If Health all Item 27 is other trau		Joan H. Imes/wif	е	12 20b. Place of	027 Pe		ra Ma	nor L			ont,M	D 21788
وَ	permit. Pages Department of the Important: If Ite any Injury or of page.		1 ☐ Burial 2 🛣 Cremation 3 🗆		cemetery	r, crematory o	r other plac						
≣	artme prtant Injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Foneral Service Light		All Co							/ille,	
g	Depa Impo any Ir		(attarine	. Dan Zl	en	404	S. Ma	in St	°⊓art . W	zler Fu oodsbor			
-e ^r ,			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each li	d the death. Do n ne.	ot enter the m	ode of dyir	ng, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
4.7	Physician		Immediate Cause (Final disease or condition resulting in death)	a septic	shock								Onsot and Death
	/Medical Examiner		resulting in death)		a consequence o crobial		omia						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence o		CIIII a						
	cuted nd ransit	Examiner	that initiated events	c. pneumo	nia								
ð,	e exe ien ai urial-t		resulting in death) Last		a consequence o	•			_				
8760,	cate be executed physicien and the burial-transit	dical		d. ventil	ator dep	endent	resp	irato	гу та	llure			
ž 6	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d	Date of deli	verv
Box	atter of for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death	3 ☐Ectopic 5 ☐ Other		<i>'</i>			250	Month	Day Year
О	that the dended by the a	hys	9 Unknown	9□ Unknown									m-
	The law requires that the death certificate hes been signed by the attending I age 2 should be detached for use as	by P	Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underlyin	g cause giv	en in Part I	l.	23e. Did to	acco use		the cause of death?
Vital Records,	w require been sign									1 □ Ye	s 2 🗆 N	o 3∏Pro	obably 4 ⊠Unknown
ပ္ပ	e law re hes be je 2 sh	Completed								24a. Was a autops		4b. Were au	topsy findings available
<u> </u>		9								perform	ned? 2☑No	death?	2 No
Ħ	ilcian: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	11			l ou		e of Death	(Check only on	θ)		
5	Physician: this certific ral director.	မ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati				4 🗆 140		e 5 Reside			cify)
Division of	ding After fune	ion	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju (Month, Da	ry Year) 28b. T	njury M	28c. Injur Wor	rk? Yes 2□		3d. Describe ho	w injury or	curred	
<u>is</u>	ten feat tor: the	fical	3 ☐ Suicide 6 ☐ Could not b	28e. Place of In	jury - At home, fai							umber or Ru	ral Route Number,
	s effer al Dire	Certification:	4 Homicide determined	building, e	ic. (Specify)					City or Town			
	To the Hospital or Al within 24 hours efter of To the Funeral Direc completely filled in by	Medical C	(Check only 2 Medical Exar	ysician: To the bast niner: On the basts of	of examination and	death conum	ed at the til	me date ar opinion, dea	nd place, ar ath occurred	nd due to the its d at the time, d	us (s) an ate and pla	mannar as	stated to the cause(s)
	To the ty within 2 To the I complete	Med	one) 29b. Signature and title of certifier	and manner st	at60.		29c. Licens	e number		2	9d. Date s	gned (Monti	h, Day, Year)
)			Wh. 11 0.12	Zu.			772		つつ		2/1	8/0	フ
	WJL	1	30. I me and address of person who	completed cause of	death (Item 23a) (Type, Print)	1) 2	13	/				_
	10		Ophnell Cumbe				Driv	e Ch	neverl	ly, MD	20785		
	St	ate	31. Date filed (Month, Day, Year)		rar's Signature								

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 27 tate of Maryland, 537 14707 din Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 10:20 AM February 15,2007 James Edward /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Perru Point
If Under 1 2 dar | If Under 24 Hrs.
Months | Days | Hours | Min. VA Marijand Heath Care System

5. Social Security Humber 6. Sex 7. Age 1th yrs. last birthday) recil 8. Date of Birth (Month, Day, Yea 8-21-27 Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 79 Buckingham PA 171-22-6071 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State rthen "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Oxford 47 West Locust St. Chester Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 47 West Locust St. 19363 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 Yes 2 No Specify: Maryland 21215-0036 Specify: White WWII 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other then Elementary/Secondary (0-12) Education Administration 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) 2 should be f and Mental h Elizabeth Erwin Calvin James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 :
Department of Health ar
Important: if item 27 is
any injury or other trau 47 West Locust St. Oxford, PA 19363 Pauline James Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☑ remation 3 ☐ Removal from State Leola, PA 17540 Evans Crematory Feb. 17, 07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licensee 22. Name and Address of Facility Edward L. Collins Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 86 Pine St. Oxford, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Guillain-Barre Syndrome Unknown Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and the burial-transit Due to (or as a consequence of): Completed by Physician/Medical use as i 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 3 Ectopic pregnancy Month Year Dav 5 Other (specify) deteched f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2X No 1 Tes 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after deatl Director: the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3
Suicide determined 4 - Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 15, 2007 licia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Mejecia Santos, M.D. VA Marybra Health Care System, Perry Paint, MD 21902
31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

	1 - For State Registrar	State of Marylar		nt of Health and te of Death		iene	7	08042
	1. Decedent's Name (First, Middle, La	st)			2. Date of Deat Month	h Day	Year	3. Time of Death
Physician /Medical Examiner	ANITA 4a. Facility Name (If not institution, given	CHRISTINA re street and number)	KREIS.	EL y, Town, or Location of Deal	March	6,		10:20 P ^M
2 Administra	Upper Chesapea	ke Medical	Center	Bel Air	r		Harf	ord
Funeral Director	5. Social Security Number 6. 9 218-80-2710	Sex 1□ M 2 X F 7. Age (<i>In yr</i> s.	last birthday) If Und	er 1 Year If Under 24 Hrs s Days Hours Min	(Month, Day,	Year) L922	9. Birthpla Countr Mar	ace (State or Foreign y) yland
death with the Maryland death with the Maryland time 23e or 28e-f show it must be notified at neral Director	Usuaf Residence of Decedent 10a. State 10b. County Har	rford 10c. Ci	ty, Town or Location	Forest Hi	11		100	d. fnside City Limits 1 ☐ Yes 2 ▼ No
or 284	10e. Street and Number		10f. 2	Zip Code	11	0g. Citizen of	What Countr	ry?
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more, Ma	William L. Kr∈ 20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □ 4 □ Donation 5 □ Other (Special Content of the Cont	eisel/Son Removal from State (b) Ca	1808 Al Place of Disposition (N cometery, crematory of	emation 3/	Fores	st Hil 20c. Location	ll M City or Tow	d. 21050 vn, State
Baltin permit. I Departm Importa any Injui	21. Signature of Funeral Service Lice	n turk		and Address of Facility G. Kurtz &				
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P.O. Box 68 nat the death certificat d by the attending ph, lelached for use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ū No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 Ectopic				ate of deliver	y Day Year
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Vital B	25. Was case referred to medical examiner?	Hospital:		Other	ath Check only on			
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Division/ talor Attending Praster dea h. al Director Atter ed in by the funer Certification:	3 Suicide 6 Could not l 4 Homicide determined			ory, office	28f. Location (St City or Town		nber or Rural	Route Number,
DIVI To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by Medical Certiff	29a. Certifier (Check only one) Certifying P 2 ☐ Medical Exa	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the caurred at the time, d	ause(s) and mate and place	nanner as sta , and due to	ated. the cause(s)
within To the comp	29b. Signature and title of certifier		2	9c. License number		9d. Date sign		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State 2-28-07 Registrar Amend#26.PerPhys.PCCcr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mahmuda Beaum Khan 2-21-2007 10:00a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 14003 Artic Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9-14-1940 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F 217-88-7459 66 India Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic event. 10c, City, Town or Location 10a State 10d. Inside City Limits Director Maryland Montgomery Silver Springs 1 TXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 6 Fox Hall Ct. Pakistan Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Asian 1 ☐ Yes 2 X No Specify. 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barkat Ali Sakeena Begum 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3127 Hel Sel Dr., Silver Springs, Md. 20906 Jamil Khan - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Wash. Cemet. 20a Method of Disposition Date 20c. Location - City or Town, State 2-22-07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Adelphi, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal, X Funeral Service Lie ^{22. Name and Address of Facility} Universal II Mortuary 411Kennedy St,N.W.,Wash,D.C. 20011 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 Carcinom Metastatic chol ang disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ut) Examiner or Attending Physician: The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 **X**No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Accidence 6 Nother (Specify) Son's Home 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗡 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rockville W WSK 1355 PICCULD benevieve Nrob 0 MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

28

32. Registrar's Signature

			For State Registrar	State	of Mary	land / Depa/ <i>Cei</i>	artment of F		and Menta		ene () ()	7	08044
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	min		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	r Location o	of Death		4c. County of	of Death	
			Carroll Hospice		_		Westmi				Car	roll	
Fune			5. Social Security Number	6. Sex 1 ☐ M 2/C XF		n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. (M	te of Birth o <i>nth, Day</i> , Y		9. Birthp	lace (State or Foreign
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land			10a. State 10b. County		10	c. City, Town or Lo	cation					1	0d. Inside City Limits
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deati		Funeral	11. Marital Status	12. Was De	cedent Eve	r in U.S. 13.	Was Decedent of H	lispanic Orio	gin? (Specify Y	es or No-	14. Race	- Americ	an Indian,
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aryla		-	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Numbe				State, Zip	Code)
re, Maryla s 1 and 2 should f Health and Men item 27 is marke			Clifford Keffer	: Hus	band	2012	Suffolk	Lane	Finksl	ourg,	MD 2	1048	
S 1 a s 1 a	Š		20a. Method of Disposition	- 55		20b. Place of Dispo	sition (Name of natory or other place	ce)	Date	20	c. Location - (City or To	wn, State
altimore, mit. Pages 1 ar partment of Hea port-nt: If item	2		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			Sandy Mou	nt Cemete	ery 2	2/28/07	F	inksbu	rg, l	Maryland
Baitimore, permit. Pages 1 an Department of Heal Important: If item 2	ODCE.		21. Signature of Funeral Service	License		22	. Name and Addre	ss of Facility	Pritts	Funer	al Hom	e & (Chapel, PA
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Physic	an		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	SI	XGZ	DE	ME	NT	1 A	1	Interval Between Onset and Death
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death death	5	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	nant at tim]Ectopic pregnancy] Other (specify)	/ 			Mon	th	Day Year
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DIVISION Of VITA To the Hospital or Attending Physicien: within 24 hours after death. The Funeral Director After this certific	completely linea		29a. Certifier 1 Certifyin (Check only 2 Medical	ig Physician: To I	ie best of n	y knowledge, death amination and/or in	occurred at the tir	ne, date and	d place, and du	e to the cau	se(s) and man	iner as si	alled.
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6			30. Nam and address of perion	who completed ca	use of deat	n (Item 23a) (Type,	Print)	CL	act 1.	DEN 11	Ktar 1	1	2157
	Sta	te	31. Date filed (Month, Day, Year)	32.	Redistrar's		J. COUL	۱۱۷	CCT C	KAMIL	will it	1112	XINI
Reg	gistra		FEB 2	7 2007	Mesu	U K A	parte						

Amended Item 23a Part I and 23b per Physician 02/26/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb 21 **Physician** 200[¥]/^{eai} 4:00 P M Linton Lynn Vickie /Medical 4c. County of Death Carroll 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Woodbine Examiner 5532 Bethel Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD **Funeral** 1 □ M 2 □ F 219-70-9867 43 Apr 13 1963 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Woodbine Carroll MD Funeral Director 1 ☐ Yes 2 ☐ No 10f. Zip Code 21797 10e. Street and Number 10g. Citizen of What Country? 5532 Bethel Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No if Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Irene (Treasler) ပ C. Wright Jr Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5532 Bethel Road Woodbine, MD 21797 Husband David Linton, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodbine, MD Feb 26 2007 Pleasant Ridge Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home 21. Signature of Funeral Service Lice e aun le 1212 W. Old LIberty Rd., Winfield, MD 21784 the paused the die h. Do not enter the mode of dying, such as cardiac or respiratory arrest, se in each line. art1. Inter the disease, or complication shock, or heart failure. List only one care Approximate Interval Between Onset and Death Immediate ause (Final diseas or condition resulting in death) **Physician** 3 Years /Medical Due to (or as a consequence of) Examiner > 5 Years Sequentially list conditions, if any learning to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner > 5 Years burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA Medical Certification: To 1 🔲 Inpatient 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. use as the for page 2: Hospital or Attending Physician: funeral director, this s after decral Director: Afr filled in by To the Hospital within 24 hours a To the Funeral Completely filled

3altimore, Maryland 21215-0036

WIL

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title o

person who completed cause of death (Item 23a) (Type fin) 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITM 24 au 26 eparty ell of G865 13/14/07 vis Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death TOXING ,200 March 5 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Secours Has If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
JULY 24, 1936 . Age (In yrs. last birthday) VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MARYLAND 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2012 RUXTON AVENUE U.S.A.Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: BLACK <u>\$</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL WORKER MENTAL HEALTH 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELOUISE CONAWAY LEE MATTHEWS HAROLD MATTHEWS ဂ္ 19a. Informant's Name/Relationship (Type. Print)
DOROTHY CURTIS (AUNT) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2012 RUXTON AVENUE BALTIMORE MARYLAND 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 3/10/07 LIVELY VIRGINIA CHURCH OF DELIVERANCE 4 ☐ Donation 5 ☐ Other (Specify) 21. Si natu 22. Name and Address of Facility BERRY
6784 MARY BALLER BALLER AD
LANCASTER VA. 22503 of Funeral Service Licensee O. WADDY 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Fina Exacerbation disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? /es 🚻 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 🙀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Physician /Medical Examiner certificate be executed P.O. Box 68760, The law requires that the death or Vital Records, Division

sician and burial-tran attending physician for use as the buria the detached ģ has page 2 certificate Attending Physician: director this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral To the Hospital or

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Medical Certification:

Physician

Funeral Director

28a-f show

ral", or Items 23a or 28a-f shore Examiner must be notified at

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Hygiene.

Pages 1 and 2 should be filed inent of Health and Mental Hyginnt: If Item 27 is marked other

permit. Pages 1 and 2 s Department of Health at Important: if Item 27 Is any Injury or other trau once,

the Medical

traumatic

within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

State Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000

DODS 2950 March 5, 2007 Boffmore, MD 31223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For 3-2-07 AMEND#15 20B-20C PFR FH FOUR Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

1- State 3-2-07 AMEND#27 DERMIND COR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Ciria Edith Gomez Lawrens 0844 M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pronce Georg 25 6 everes HOS DITE If Under 1 Year Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 25 F 40 Yrs. Director 218-57-1213 Honduras Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f ehor The Madical Examiner is ust by publified at 1 Yes 2 No Directo Maryland Prince George's Hyattsville 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 6800 Highview Terrace #104 20782 Honduras by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married 1 ☑Yes 2 ☐ No Specify: Specify: White Honduran 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Person Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked o Reynaldo Gomez Inez Lawrens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5926 Brin Mawd, College Park MD 20740 Daisy Gomez (Sister) Health 20b. Place of Disposition (Name of cometers, crematory or other place)
Hall Cemeterio
Gate of Heaven Cem 20c. Location - City or Town, State El Progreso, Yoro, Honduras 20a. Method of Disposition 3-10-07 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or pnce. 4 □ Donation 5 □ Other (Specify) 3/3/2007 Silver Spring, 21. Signatura of Juneral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 23a. P.ri1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between m mediate Cause (Final disease or condition resulting in death) Onset and Death 4 do ma Cevebra **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit Physician/Medical as the attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tibion Mateau 1 Yes 2 No 3 Probably 4 Unknown been si Completed Dullhonam 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No is certificete h director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one. examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA neral Director: After thi 28b. Time of Injury 28d. Describe how injury occurred Pedes from 27. Manner of Death Certification: Natural 5 Pending investigation Gruay 18,20 1 Yes 2-No 2 XAccident STreet 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, arm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) BALL COLOR 4 Homicide College Fare

To the Hospital or At within 24 hours after of To the Funeral Direct Medical

death.

the Maryland

Baltimore, Maryland 21215-0036

certificate be executed

Box 68760,

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of Vital

Division

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifies

NIU AM BOY

29a, Certifier



cause of death (Item 23a) (Type, Print)

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Descripting Physician: To the best of my knowledge, orath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number / 1055737

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 7 Day 200^Y7 **Physician** 7:34 pm MATTHEWS ADELE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kent Galena 31857 Griffith Dr. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. Nov 11 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Jersey 1 □ M 2 🕶 F 1917 New 89 150-20-2383 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a, State r then "natural", or items 23a or 28a-1 show the Madical Exertine must be notified at 1 ☐ Yes 2 X No Director Galena MD Kent 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21635 U.S.A. 31857 Griffith Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status within 72 hours after 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 No Specify: Specify: Maryland 21215-0036 Š 3 TX Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Catering Service Waitress 12 7 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental H Pages 1 and 2 should be tment of Health and Menta tent: If item 27 is marked Eva Pelutis Peter Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31857 Griffith Dr. Galena, MD. 21635 (daughter) Joyce Flach Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Hollywood Cemetery 3/13/07 Union, NJ. crtsnt: h 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Galena Funeral 118 West Cross 21. Signatura + F)neral Service Licent L Schaech 21635 Deportre Deportre Importa any ni Stephen ena, MD. Home of Step St. Galena, Gale 118 M00510 West 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Oron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires thet the death certificate be executed VILL physicien and the burial-tran and Due to (or as a consequence of) Box 68760, Physician/Medical ettending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 TEctopic pregnancy Day Year 5 Other (specify) signed by the e P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has b lirector, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director Be Other: Hospital: 4 Nursing Home 5 Hesidence 6 □Other (Specify) ٩ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this : After this funeral of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification; Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation efter death Director: / d in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 - Homicide within 24 hours e To the Funeral C completely filled 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifief Medical 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) North Main St. Galena, MD. 21635 119 C. Donaher, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 4 2007 Registrar

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		Registrar 1. Decedent's Name (First, Middle, Last)		Cei	illicate of t	Jeani	2. Date of D	Reg. No.	Щ./_	3. Time of Death
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/Medica Examine		4a. Facility Name (If not institution, give stre	et and number)	, , , , , , , , , , , , , , , , , , ,	4b. City, Town, or	Location of Dea			ity of Death	3:40 A
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orher tra	-	20a. Method of Disposition	20b. F		sition (Name of matory or other place		Date		n - City or To	wn, State
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w requires that been signed to should be detailed.	2						1 🗆	Yes 2 No	3 KProb	ably 4 Unknown
The law required has been so page 2 should							24a. Was		b. Were auto	psy findings available
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I have a modified to be the funeral director, I have formed to be the funeral director.		4 ☐ Homicide determined	building, etc. (Speci	(y)	oot, labtory, office		City or To	wn, State)	moer or riura	r route vumber,
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o the Hosp ithin 24 hou o the Fune ompletely fi	ב <u>ו</u>	(Check only 2 Medical Examiner one)	On the basis of examination and manner stated.	ation and/or in	vestigation, in my o	pinion, death of	ccurred at the time	, date end plac	e, and due to	the cause(s)
To the To the COURT	ž	29b. Signature and title of certifier			29c. License			29d. Date sig		
						103 53	cs	03-0	1- S	007
3x1			126 Opal Cou	rt, Ha	gerstown	, MD 21	1740			
State Registra		31. Date file MAR, 1 av 4 Ye 2007	32. Registrar's Juna	ature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1011 George Thomas McGuckian 02 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** EASTON TALBO 8. Date of Birth (Month, Day, Ye MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) - 1929 **Funeral** Days **X** M 2 □ F Maryland 213-30-1674 77 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Talbot Easton Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 28483 Pinehurst Circle 21601 U.S.A. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1946–54 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ò White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Professor College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Charles McGuckian Mary Elsie Leitch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any In]ury or other trau Thomas G. McGuckian/son 5704 Harmony Road Preston, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2/28/2007 Baltimore, Maryland Baltimore Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic Obstructive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for esta consequence of) Examine and Due to (or as a consequence of): Box 68760. ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? this certificate 1□ Yes 250 or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOO 53110

Registrar

State

219 S. Washington Street Faston, MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Dr. Dennis DeShields

FEB 2 7 2007

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryla		artmer rtificat			and M	ental F	lygien Reg. No	11111	08051
÷ 3.	Physici		1. Decedent's Name (First, Middle, Last) Margare	t L. Moo	re				I	2. Date of Month		^y 2007 ^{Year}	3. Time of Death 5:12P M
	/Medio		4a. Facility Name (If not institution, give s National Luthe			1		Location o			40	County of Death	h
190	Funeral Director		133 10-04/0	7. Age (In yr M 20 F 86	rs. last birthday) Yrs.	If Unde Months	n 1 Year Days	If Under 2 Hours	Min.	8. Date of (Month, July	Birth Day Year IO, I	9. Birtl Co Ne	nplace (State or Foreign untry) W Jersey
	Maryland i-f ehow	tor	Usual Residence of Decedent		City, Town or Lo	ocation Vill	.e						10d. Inside City Limits 1 AYes 2 No
	th with the 23a or 28a INI be not	al Director	10e. Street and Number 9701 - Veirs D:	rive		10f. Zip	Code 2085	0				tizen of Whaf Co	untry?
9036	riit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland artiment of Health and Mental Hyglene. ortant: If Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow injury or other traumatic event. The Medical Examining rout the routling at a	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto f	cify Yes or Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh	e, etc.
Maryland 21215-0036	d within 72 ho jiene. r than "natur ine Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	ation completed) Colfege (1-4or 5+)	_	dent's Usu kind of wo DO NOT u	ork done a se retired	ation furing most)	of working	ng	16b. K	Cind of Business/I	
yland;	2 should be filed and Mental Hygi Is marked other surnatic event,	To Be C	17. Father's Name (First, Middle, Last) Bernard Love	9						(First, Mide Ce C		1 Sumame)	
	t and 2 shot Health and tem 27 is mother traum		19a. Informant's Name/Relationship (Type Ronald Moore –		19b. Mailii 1831	ng Address . 9 HC	(Street a	Loci	r or Rura ust	Circ	nber, City 1e, G	or Town, State, Z aither	sburg,Md.
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, crei ropoli			matoı		ate 2/23/	20c. L 07 – A	ocation - City or 1	Town, State ria, Va.
Balt	permit. Departi Import. any inj		21. Signature of Funeral Service License	1		Hysc	ng (s of Facility	Inc.	Was	hing	sconsiton,DC	n Ave.,NW 20007
-	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on fmmediate Cause (Final disease or condition resulting in death)	Pelvic		M O	_	g, such as o	cardiac oi	respiratory	y arrest,		Approximate Intervat Between Onset and Death
	icate be executed by sician and by sician and sihe burial-transit	dical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	U.	(a)	lur	e 					n cerths
	The law requires that the death certificats ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Medic	#F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. ff yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pi Other (sp						23d. Date of deliment	very Day Year
rds, P	w requires that been signed b should be deta	þ	Part fl. Other significant conditions cont	nbuting to death but not re	esulting in the u	nderlying o	ause give	n in Part I.					the cause of death?
Division of Vital Records,	. The law requ	Completed			·						topsy rformed?	prior to c deafh?	topsy findings available omptetion of cause of
Vita	ician sertific ector,	Be	25. Was case referred to medical examiner?				Lou		of Death	Check onl	one		
ō	Phys this al dir	5	1 Yes 2 No	ospitaf: 1 Inpatient 2				4 (Limitary				6 ☐Other (Spec	aty)
ion	Attending Physician: r death. setor: After this certifica by the funeral director, y	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Infury	M	8c. Injury Work 1 ☐ Y	at ? ′es 2□N		8d. Describ	e now inju	ry occurred	
DIX		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At building, etc. (Spec	city)					City or 1	Town, State	9)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of my ki er: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred vestigation	at the tim , in my op	e, date and inion, death	d place, a h occurre	nd due to the d at the tim	ne cause(s e, date and) and manner as d ptace, and due	stated. to the cause(s)
	To the within 2. To the complet	Me	29b. Signatuje and title of certifier	1/2	1	290	License		/	7-7	Ti	te signed (Month	
2	2		30. Name and address of person who com					72				ruary	12,2007
18	Sta	te	DR. CHARLES W			-VEI	RS I	OR.,	ROC	KVIL	LE,M	D.	
74	Registr		31. Data FEB 2"8"2007	32. Registrar's Sign	Operte	,							

VOID

CERTIFICATE

2007-08052

SEE

CERTIFICATE

2007-07302

Deceased name-Lewis Roger Moore

G-1-07 Diniki Taylo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Vaar **Physician** February20200 70851 AM ar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner More 6hns 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Davs Months 1 ☑ M 2 ☐ F Hours Yrs. 58 578-62-5184 17, 1948 Maryland June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director Bel Air Harford Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21014 U.S.A. 717 Country Village Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2X No Specify: Š Specify: 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 dentist dental healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Daniel Metz Jr. ၉ Eileen E. Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott M. Metz/ son 102 Kirsten Ct. Parkton, MD 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation — 5 ☐ Other (Specify) Pipe Creek Cemetery 2/23/2007 nr. Linwood, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Furfaral Service License atharine Libertytown, MD 21762 11802 Liberty Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertensive Atherosclemotic Cardronoscular disease Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

injury

Funeral

Director

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ir then "natural", or iteme 23s or

it. Pages 1 and 2 should be filed within 72 hours after riment of Heelth and Mental Hygieno.

The state if item 27 is marked other then "natural," or ite email: if item 27 is marked other then "natural," or lite injury or other traumatic event," its Madical Examina

Baltimore, Maryland 21215-0036

with the Marylend or 28a-f show

> ettending physicien and for use as the burial-trans Completed by Physician/Medical signed by the e peeu s certificate has t lirector, page 2 s director, Be ပို this Medicai Certification;

The law requires that the death certificate be executed or Attending Physician; To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir

Division of Vital Records, P.O. Box 68760,

25

ormed? 2**X** No 1 ☐ Yes 26. Place of Death | Check only one

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 2X No

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier

25. Was case referred to medical examiner?

27. Manner of Death
Natural
Coldent

3 T Suicide

29a Certifier

4 Homicide

29c. License number RES-000

30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Danesh Maz loomdoost 600 North Wolfe Baltimore, Mary land 21287

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 6 2007

		For	State of Marylan		•		Mental Hyg	giene		
	_	1 - State Registrar			Certificate of	Death		Reg. No.	2007	08054
Physi	cian	1. Decedent's Name (First, Middle, La					2. Date of Dea	Day	75 Year	3. Time of Death
/Med		Leo Richar 4a. Facility Name (If not institution, gi			4b. City. Town. o	r Location of Deat	rebrua	7	るつ, dの County of Deat	
) Exam	iner	Civista med	ical Cent	Pr	LaP	LaTa	.,	0	harl	196
Funera	al T	,	Sex 7. Age (In yrs.		Months Davs	If Under 24 Hrs Hours Min.	8. Date of Birth	Year)	9. Birt	thplace (State or Foreign ountry)
Directo	r	234-32-8838	1MM 2□F	81 Y	rs.	110010	August	17,1	925 We	st Virginia
land ow rt		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town	or Location					10d. Inside City Limits
Mary a-f shi ffied a	ż	MD St. Man	ry's	Co1t	on's Point					1 ☐ Yes 2 🖔 No
th the or 28; e not	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Co	puntry?
ath w s 23a nust b	ral	20560 Richard V			20626				USA	
ter de items	Funera	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1♥ Yes 2 □ No	.S.	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	1	 Race - Ame Black, White 	
hours af ural", or	à		If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:			Specify:	white
72 ho	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	16a. I	Decedent's Usual Occup	ation	rkina	16b. Kir	nd of Business/	Industry
vithin ne. han "	l de	Elementary/Secondary (0-12)	College (1-4or 5+)	,	lite. DO NOT use retired Coal Min	d)	9	-	1 361	
filed v Hygie ther t		17. Father's Name (<i>First, Middle, Las</i>]	COAL FILE		me (First, Middle,		oal Min:	ıng
ytaria z 1 z ould be filed with Mental Hygiene. arked other than	To Be	Richard Jackson	Mvers				er Paulin		,	
IdTyidTIQ ZIZID-UUJO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship		19b.	Mailing Address (Street					Zip Code)
and 2 and 2 auth n 27 l		Mary Kay Myers/D			0. Box 1 Co	lton's E	Point,MD	206	26	
TOTE, INITIVIATION ATAINONS Ges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [cemetery	Disposition (Name of , crematory or other place	pe)	Date		cation - City or	·
mit. Pages partment of portant: If it py injury or or		4 ☐Donation 5 ☐ Other (Spec.	**************************************		nt Valley C				and, Mar	ryland
Dalitinole, IVI	1	21. Signature of Funeral Service Lice	Ehul		22ANEHART					
F-1-1-14		23a. Part1. Enter the disease, or cor	nplications that caused the deat	h. Do no	211 St. Mot enter the mode of dyir				MD 200	Approximate Interval Between
Physician		shock, or heart failure. List only immediate Cause (Final disease or condition	y one rause on each line.	C_{i}	CONTROL	1 ARTY	of Tun.	× DX	E	Onset and Death
/Medica	l I	resulting in death)	Due to (or as a conse):	11/00/11	3100/1243	C)	- X-	700000
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ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
execu n and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):					
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	(S.3							
ertificat ing phy	Med	IF FEMALE:								
ath cer ttendir or use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1☐Live birth 2☐Feta	al death	3 ☐ Ectopic pregnancy	/		2	3d. Date of deli	ivery Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	leath	5 ☐ Other (specify)					
that seed by deta	y Ph	Part II. Other significant conditions	contributing to death but not res	ulting in	he underlying cause giv	en in Part I.	23e. Did to	bacco us	se contribute to	the cause of death?
w requires to been signer should be or	ed by						14 C Y	es 2	No 3□Pr	robably 4 □Unknown
law re as bee 2 sho	Completed						24a. Was a		24b. Were au	utopsy findings available completion of cause of
The The page	Som						perfor		death? 1 ☐ Yes	
V I LC iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or:	ath (Check only or		-	
Phys r this	2	1 ☐ Yes 2 No 27. Magner of Death	1 ☐ Inpatient 2 28a. Date of Injury	ER/Outr 28b. Ti	vatient 3 DOA Other	4 Li Nursing F	dome 5 ☐ Reside			cify)
nding ith. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) on	lnj	me of 28c. Injur ury Worl	ƙ? Yes 2 ⊡ No		,		
r Atte er des recto	Certification:	3 Suicide 6 Could not be determined		ome, farr	n, street, factory, office		28f. Location (Si City or Town	treet and	Number or Ru	ural Route Number,
italo Irs afte							17			
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 29a. Certifying P 2 Medicai Exa	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, ition and	death occurred at the tir or investigation, in my o	ne, date and plac pinion, death occ	e, and due to the c urred at the time, c	ause(s) : date and	and manner as place, and due	s stated. e to the cause(s)
o the	Mec	29b. Signature and title of certifier	and mariner stated.		29c. Licenso	e number	2	29d. Date	signed (Monti	h, Day, Year)
F > F 0	_	fryt	JURU W	~	W O	206	29	2	1 2	5/07
100		30. Name and address of person who	completed cause ordeath (Iten	n 23a) (T	ype, Print)	1.10	0 0 - /	N. A.	0 0	21 25
DB881		CT (20) (C &	32. Registrar's Signa	250	V 1 V1. Y	WHY	DOKUL'	111	W-2	0603
S Regis	tate trar	31. Date filed (Month, Day, Year) FEB 2 8	32. Begistrar's Signa	K	Some					
DHMH 17 Rev 1	/2001	1 2 0 0	- I James James J							

Baltimore, Maryland 21215	permit. Pages 1 and 2 should be filed within 72
)	Ph /N Ex
lal Records, P.O. Box 68/60,	in: The law requires that the death certificate be executed

	1	_ FOF	partment of Health and M <i>ertificate of Death</i>	lental Hygie _{Reg.}	200	07 0805
Physician	n	1. Decedent's Name (First, Middle, Last) Charlotte I. Mathis			Day 23,	Year 2007 8:35 A ^M
/Medica Examine	r	4a. Facility Name (If not institution, give street and number) 303 Canberra Court	4b. City, Town, or Location of Death Frederick		4c. County	of Death ederick
Funeral Director		5. Social Security Number 215-24-7823 Usual Residence of Decedent 6. Sex 1 □ M ★ F 7. Age (In yrs. last birthda 7	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes		Birthplace (State or Foreign Country) Maryland
e Maryland la-f show tiffed at	. [10a. State 10b. County 10c. City, Town or Maryland Frederick	Location Frederick	-		10d. Inside City Limits 1 X Yes 2 □ No
a or 28	5	10e. Street and Number 303 Canberra Court	10f. Zip Code 21701	10g.	Citizen of V USA	What Country?
al", o	by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	2.1701 3. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify: cedent's Usual Occupation		14. Race Blace Specify	e - American Indian, kk, White, etc. // White
be filed within 72 ho that Hygiene. d other than "natul event, the Medical	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of work by DO NOT use retired) benemaker			n Home
d oth	lo Be	17. Father's Name (First, Middle, Last) Vernon Smith	Carrie	e (First, Middle, Mai Black		
traum		1,111	ailing Address (Street and Number or Run 03 Caberra Court, F			
of Hea of Hea fitem 2		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 20b. Place of Discernetery, of	sposition (Name of [rematory or other place)	Date 200	c. Location -	City or Town, State
permit. Pag Department Important: It any Injury o		4 □ Donation 5 □ Other (Specify) Stauffer 21. Signature of Funeral Service Licensee		tauffer F	unera]	
the has been signed by the attending physician and age 2 should be detached for use as the burial-transit and burial-transit an	ical Exal	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHF Due to (or as a consequence of): Type II DM Due to (or as a consequence of): Pulmonary Fibro				Interval Between Onset and Death
d by the attending petached for use as the percentage of the perce	nysician/ine		3 ∐Ectopic pregnancy 5 ∐ Other <i>(specify)</i>			te of delivery onth Day Year
n signed by the all the detached in the detach	6	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.			ribute to the cause of death? 3 □ Probably 4 □ Vinknow
10 17		25. Was case referred to medical		24a. Was an autopsy performed 1∐ Yes 2E		Were autopsy findings availab prior to completion of cause of death? 1 ∐Yes 2 ☐ No
this certain direct	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	of y 28c. Injury at Work?	th (Check only one) ome 5 TResidence 28d. Describe how		
Director: in by the	erillicat	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide investigation 28e. Place of injury - At home, farm, building, etc. (Specify)		28f. Location (Stree City or Town, S		er or Rural Route Number,
within 24 hours are the Funeral Completely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occur	red at the time, date	and place,	and due to the cause(s)
To To To E	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed	d (Month, Day, Year)
ь		30. Name and address of person who completed cause of death (Item 23a) (Type A 2 6 5 7 6 5 7 6 5 7 6 6 7 7 7 7 7 7 7 7 7		{○ hmans Lan	e Free	27/07 derick, MD 21
State Registrar		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 - 4			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** FEBRUARY 16 2007 7:00PM M MARION E. MUNN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **EASTON** WILLIAM HILL MANOR TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Yrs SEPT. 85 Ĩ921 MASS Director 018-14-0916 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo MD TALBOT Directo EASTON 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 or Items 23a 26949 MILES RIVER ROAD 21601 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE Completed by 3X Widowed 4 □ Divorced Year or Dates 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medis once. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM J. CLARKE ANNIE MOXLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM H. MUNN/SON 26949 MILES RIVER ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) GLENWOOD CEMETERY 2/21/2007 EVERETT, MASS. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 COHO! 2 MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 2 nos resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. the attending physician Be Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 2 🗌 No 1 Yes after death 2 Accident the 6 □ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) in by 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1008715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 501 DUTCHMANS LANE, EASTON, MD 21601 WILLIAM H. WOOD, JR., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 2 2007 Registrar

hysici		Registrar 1. Decedent's Name (First, Middle, La.	st)		rtificate of l		2. Date of Deat			3. Time of Death
		Elmer T. Myers					Month 02	23 2	007	4:40a
/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death	
		605 Rigby St.			Cambridg				heste	_
ineral	1	5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		place (State or Foreig intry)
rector	-	219-36-7088) J 118.			11/21/1	911	West	minister l
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등	io	MD Dorches	ster	Cambridg	e					1 XYes 2 □ N
or 28	Jirec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cou	intry?
23e	rai	605 Rigby St.			21613			USA		
tems ser m	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ice - Amer ack, White	ican Indian, , etc.
other then "netural", or Items 23e or 28a-1 show ant, the Medical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	√ 1/1/43 - 2/12/46	1 ☐ Yes 2 🗓 No	Specify:		Spec	ity: B1a	ick
atura cal E	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of I	Business/l	ndustry
n n	ple	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	life	kind of work done of DO NOT use retired	during most of work d)	ang			
t E	Con		5	Educ	ator					County Sc
d oth evan	Be	17. Father's Name (First, Middle, Last,				18. Mother's Nam		Maiden Suma	ime)	
natic	ပ္	Elmer Ellsworth My		105 M-105	ng Address (Street	Harvine (City or Tour	n State 7	in Code)
7 Is matrant		19a. Informant's Name/Relationship (Alda W. Myers / N	Wife		igby St.				., J.a.e, Z	, Josep
tam 27 other tra	1	20a. Method of Disposition	wile	20b. Place of Dispo	osition (Name of			20c. Location	· City or T	Town, State
it: If it y or c		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		Md Vetera	matory or other place ns Cemete		2007 H	urlock	, MD	
Important: If itam 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other traumatic evant, the Madical Examination must be notified at once.		21. Sign turn of Juneral Service Licen			2. Name and Addre			er St.	East	on, MD 2160
		23a. Part1/Enter the disease, or comshoot, or heart failure. List only	pplications that caused one cause on each lie	the death. Do not en				est,		Approximate Interval Between
sician	2 4	Immediate Cause (Final disease or condition	Adu	mercel k	sebulito	steel ST	tile			Onset and Death
edical miner		resulting in death)	a	a consequence of):						10
mmer		Sequentially list conditions,	b. Wen	wentin						10 400
ısıt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Doorto (or as	a con coquanco orp.						
0 0	, a	that initiated events	C	a consequence of):						
al-tr	X	resulting in death) Last	Due to (or as	a consequence on).						
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	Physici /Medic		1. Decedent's Name Dolores									Date of Dea Month 02/20/	Day	Year	³ 2'''10AM th 6:15A M
	Examir			iver Heal	lth and l	Rehab		4b. City, Tov Edges	wate	r			Ann	ounty of Deatl	del
	Funeral Director		5. Social Security N 220-38-12 Usual Residence of	299	Sex 1□M 2 X F	7. Age (<i>In yrs</i> . 79	last birthday) Yrs.	If Under 1 Y Months D		Hours	Min.	Date of Birth (Month, Day 0/02/1	, Year)	Cot	nplace (State or Foreign untry) nington D.C
	Maryland -f show -fed at	tor	10a. State	10b. County Anne Art	ındel		y, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 No
	with the la or 28a t be notif	Director	10e. Street and Nu	mber Llicott A) Tro			10f. Zip Co				1	10g. Citize	n of What Cou	
980	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	by Funeral	11. Marital Status	ried 2 XMarried	7	2 X] No		Was Decedent Yes, specify	t of Hisp Cuban,	anic Origi Mexican, Specify:	in? (Specify Puerto Ric	/ Yes or No- an, etc.)		. Race - Amer Black, White	ican Indian,
Maryland 21215-0036	within ene. than '	Completed	(Spec	15. Decedent's E cify only highest g ondary (0-12)	Education rade completed) College (1	-4or 5+)	(Give	dent's Usual C kind of work o DO NOT use r WNET	ecupatione duri etired)	on ring most o	of working			of Business/I Retail	ndustry
and 2	be filed ntal Hyg od othe event,	B	17. Father's Name Carl	(First, Middle, Las	it)	Ritchie	1			8. Mother'	_	irst, Middle,	Maiden Su	urname)	Ryon
Mary	d 2 should be in and Mental is marked or traumatic ever	2	19a. Informant's Na	ame/Relationship Hough			1	ng Address (Si	treet and	d Number	or Rural R		r, City or T	Town, State, Z	
Baltimore, I	ss 1 and of Healt item 2		20a. Method of Disp 1 XBurial 2		☐Removal from	20b. F	Place of Disponentery, cree Place of Disponentery, cree PLIST C	sition (Name of patory or othe hurch	of r place)	0	Date 2/23/	2007	20c. Loca Wes	tion - City or T	r,MD
Balti	permit. Page Department Important; if any injury o		21. Signature of 50	uneral Service Lice	ensee and	1	22 H	Name and Aardest	ddress y Fu	of Facility nera.	1 Hom	e P.A. Annapo	112,	Ridgel MD 2140	S1 ^{Ave}
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	0		30. Name and addi	ress of person who	completed caus	e of death (Item	23a) (Type,	Print) Wen	·k	re	Be	al film	ove	1 2	1201
	Sta Registi		31. Date filed (Mon	th, Day, Year)	100	egistrar's Signa	ature								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 18 per fd State of Maryland / Department of Health and Mental Hygiene aaco hlth dept 2/27/97 dlw Certificate of Death - Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Z /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Arundel Annapolis Anne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 13 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours 1 M 20 F Months Days 1926 513-16-5381 81 Jan Director Kansas Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at Maryland Anne Arundel Annapolis Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 930 Bay Forest Ct. Apt 310 21403 USA 1 and 2 should be filed within 72 hours after death valeth and Mental Hygiene.
Health and Mental Hygiene.
Em 27 is marked other than "natural", or Items 23, the traumatic event, the Medical Examiner musts when traumatic event, the Medical Examiner musts Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar Crosswright G Gladys Wrothwell ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. Norman(Husband) 930 Bay Forest Ct. Apt 310 Annapolis, Pages 1 a nent of Hea nt: If Item 2 y or other * 20b Place of Disposition (Name of Cometery of Place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 3 - 1 - 07Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee WinName Redese of Eacil Sons Mortuary, Taron 15, See Mo6/83 821 West St. Annapolis, 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of): **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 ☐ Yes 2 ☐ No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death, neral Director: / filled in by the f 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only

and manner stated.

Registrar's Signa

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Y☐Yes 2☐No

G

Year

29d. Date signed (Month, Day, Year)

445 DEFENSE HGHWAY ANDPOLO MD

To the Hospital or Attending Physician:

Registrar

29b. Signature and title of certifier

31. Date filed (Month

DHMH 17 Rev 1/2001

29c. License number

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 07 **Physician** March 2007 11:00PM Albert Louis Plumer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Darlington 1924 Glen Cove Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**∑**M 2□F 7/24/1934 Maryland 72 Director 218-32-8753 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "neturet", or iteme 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 ☑ No Darlington Harford Direct 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21034 1924 Glen Cove Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Equip. Office Supervisor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ruth Mary Milchling Henry John Plumer, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 61 Brer Rabbit Road, Rising Sun, MD Elaine Van Hart/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/2007 Baltimore, MD St. Joseph's Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service L 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Part 1. Enter the disease, or combligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chronic renal Means Physician /Medical Due to (or as a consequence of): 10 years Examiner Huner tension
Due to lo as a consequence of): Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of) Box 68760, ettending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 8 30 No 3 Probably 4 Unknown y mphocy tic leukemia 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performe 2 🗆 No certiticate 1 Yes 28 No 1 Tyes or Attending Physician: 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 🗡 No 3 DOA 2 ER/Outpatient this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours etter death.

To the Funeral Director: Alcompletely filled in by the fu investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies hulle 020340000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Parkestreet # 400 Aberdeen MD 2 20 MD15 Prashant 31. Date filed (Month, Day, Year) 12. Registrar's Signature State Registrar MAR 1 4 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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with the	t be not	Il Direc	10e. Street and Number 6824 Bock Road	Apt. 411		10f. Zip Code 20744			10g. Citizen of W USA	nat Countr	y?
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.	or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ऄ No		pecify Yes or No- to Rican, etc.)	14. Race Black Specify:	- America , White, e Whi	tc.
within 72 ho lene.	he Medical	Completed	15. Decedent's I (Specify only highest g	Education rade completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired Driver	eation during most of wor d)	rking	16b. Kind of Bus		ustry
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene.	tlc event, t	To Be Co	17. Father's Name (<i>First, Middle, Las</i> Bernard	Powel1			18. Mother's Nar Louise	me (First, Middle,		ehea	d
ind 2 shoualth and N	er traumal		19a. Informant's Name/Relationship Fay Courtney / S			ng Address <i>(Street</i> Locust I					Code)
Pages 1 a	ıry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State Ka1	emetery, cre	osition (Name of matory or other pla ematory	^{ce)} 2/24	Date / 2007	20c. Location - C Edgewate	-	
permit.	any Inju		21. Signature of theral Service Lic	els Th		eorged Address					5
Physi /Me Exan	dical		23a. Part Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death y one cause on each line. a. Due to (or as a consequ	n. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
tificate be executed	10 the Funeral Director, After this confined that been sugged by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence) Due to (or as a consequence)		, , , , , ,		, v . v .			
The law requires that the death certific	ched for use as 1	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date Mor	of deliver	ry Day Year
uires that	I signed by	þ	Part II. Other significant conditions	s contributing to death but not resu	ulting in the u	underlying cause giv	ven in Part I.				e cause of death?
The law requires t	page 2 shou	Completed						24a. Was autor perfo	osy p ormed? d	rior to con eath?	psy findings available apletion of cause of
ysician;	director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Oti		ath <i>(Check only d</i>		r (Specify)
I or Attending Physician: after death.	y the funeral	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	be 280 Place of injury At he	28b. Time of Injury	M 1□	ny at rk?]Yes 2 ∐No	28d. Describe I	how injury occurr	ed	
To the Hospital or Attend	ly filled in b			building, etc. (Specify Physician: To the best of my kno	y) włedge, dea	th occurred at the t	ime, date and plac	City or Tou	wn, State) cause(s) and ma	nner as st	ated.
To the Howithin 24	complete	Medical	(Check only 2 ☐ Medical Exone) 29b. Signature and title of certifier	aminer: On the basis of examina and manner stated.	mon and/of I	29c. Licen		uneu at the time,	29d Date signed	(Month, L	Day, Year)
R	2)		30. Name and address of person whilliam T. Tann	no completed cause of death (Item er, M.D. 11701	n 23a) (Type Living	, Print)		shington		•	22,2007

Registrar

FEB 2 8 2007 32. Registrar's Signatu

			1 - State Registrar	State of Marylar		artment of rtificate of		F	Reg. No.	7 08064		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Carole Ann Pfei	fer				2. Date of Dea Month Februa	Day Y	3. Time of Death 2007 12:00p ^M		
	Examin	- st.	4a. Facility Name (If not institution, give s 11060 Weymouth	Ct.		4b. City, Town, Waldo	orf		4c. County of Char	cles		
	Funeral Director		216-70-9574	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Yea Months Days		Min. 8. Date of Birt (Month, Day	y, Year) 20,1938	B. Birthplace (State or Foreign Country) WashingtonDC		
	sa-f ahow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Charl		ty, Town or Lo	f		1	10d. Inside City 1 ∐ Yes			
	with th	Dire	10e. Street and Number 11060 Weymouth	Ct.		10f. Zip Code 20 6			10g. Citizen of Wh	- '		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural; or items 23e or 28e-f ahow appriquity or other traumatic event. It a Medical Erain art must be notified at once.	by Funeral		2. Was Decedent Ever in U Amed Forces? 1 ∐Yes 2 ☐XNo If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Black, Specify:	- American Indian, White, etc. White		
21215-0036	within 72 houene. Than "natural and a matural Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2		(Give	dent's Usual Occ kind of work don DO NOT use retii	e during most d	of working	16b. Kind of Busi				
land 2	should be filed and Mental Hygi s marked other umatic event.	To Be Co	17. Father's Name (First, Middle, Last) William Reedy E	Bartley			Cat		izabeth	n Hawkins		
Man	d 2 sho th and 7 is mu trauma		19a. Informant's Name/Relationship (Type Pamela Larrimer	oe, Print) Daughte	19b. Mailii 211			or Rural Route Numbe Dr., Wald				
Baltimore, Maryland	Pages 1 and nent of Health Int: if item 27 Iry or other to		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	Place of Dispo cemetery, crea	osition (Name of matory or other p	Marc	Date h 1,2007	20c. Location - C	nd, Maryland		
Balti	permit. Departmit.imports any inju		21. Signature of Funeral Service License	M006	68	4270 Ha	awthor	eral Home	e, P.A. Indian H	20640		
I	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Pinal disease or condition	cations that coused the deale cause of each line.	th. Do not en	ter the mode of d	ying, such as co	LILMUN M	y Dise	Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death) . Sequentially list conditions,	Due to (or as a consec	quence of):							
0,	cate be executed by sicien and the burial-transit	T any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
8760,	physicis	dicai										
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3[□Ectopic pregnar □ Other (specify)	ncy		23d. Date Monti	of delivery h Day Year		
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	-		, ,	given in Part I.	23e. Did t	/	oute to the cause of death? B Probably 4 Unknown		
Division of Vital Records,	The ate h page	Completed	Colomfo	1 Azizery	Dis	ene			ormed? pri	ere autopsy findings available for to completion of cause of eath? Yes 2 \(\) No		
Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	lospital:	7.FB/O	-1 25 501	Other	of Death (Check only of Sing Home 5. Resi		(Caseta)		
ion of	ing After une		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of finjury	III JUDON	d					
Divis	tai or Attend rs after death ai Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	reet, factory, office	Э	28f. Location (City or To		r or Rural Route Number,			
	To the Hospital within 24 hours a To the Funeral Completely filled	edical		sician: To the best of my kn ner: On the basis of examin and manner stated.		nvestigation, in m	y opinion, death		date and place, ar	nd due to the cause(s)		
)	To the within 2 To the complet	Σ	29b. Signature and title of certification) MO			H250	3		(Month, Day, Year)		
(183		30. Name and address of mon who co	mpleted cause of death (fte	m 23a) (Type,	Print)	HLUD (WEPURF	, MP,	2-1037		
1	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	Cart .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month Physician Lois Padgett 8:00 a.M February 24. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11 Rosewood Court Woodsboro Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F 549-05-4130 90 Director December 18, 1916 California Usual Residence of Decedent 10c, City, Town or Location show 10a, State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Maryland Frederick Woodsboro Director X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Rosewood Court 21798 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No white Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Nassau County Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward H. Sanderson Della Nelson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Katharine Powell 2826 Wildwood Court, Walkersville, Maryland 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Glade Cemetery 4 Donation 5 Other (Specify) 3-2-2007 Walkersville, Maryland 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home ellue 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 days **Physician** /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ceclar Disoaxo sician and burial-trans Due to (or as a consequence of) attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 10 in the past 12 months? 1☐ Yes 2☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ be 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 No certificate anacellar 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No death.

Examiner certificate be executed Box 68760. P.O. Records, Division or Vital Hospital or Attending

Baltimore, Maryland 21215-0036

Certification:

within 24 hours after death To the Funeral Director: completely filled in by the

2 Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

195 Thomas Johnson Drive, Frederick, Maryland William H. Convey, M.D. 31. Date filed (Month, Day, Year)

State Registrar

Medical

gistrar's Signature FEB 2 8 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb. **Physician** Mark E.Redding 20 2007 8:45PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Hospice Westminster Carroll 8. Date of Birth (Month, Day, Year) Feb. 16, 1930 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) PA 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1 M 2 F 180-22-3928 77 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other than unatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director PA Adams Hanover 10f. Zip Code 10e Street and Number 10g Citizen of What Country? 5 Cherry Valley Road 17331 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Øyes 2 No If Yes, Give Year or Dates: 1950 3 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify à Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Auto Manuals 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvester ျှ Redding Laura Eckenrode 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Redding -Cherry Valley Rd. <u>Hanover, PA17331</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) St. Aloysius Cemetery 22. Name and Address of Facility 2/23/07 Littlestown, PA 21. Signature of Funeral Service Licenses Ruhard dittle Little's FH 34 Maple Ave.Littlestown Approximate enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ساليومد /Medical Due to (or as a conso uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 | Yes 2 | No 3 | Probably 4 | donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1∐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6-Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 lours a 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2

WIL 15

> State Registrar

29b. Signature and title of certifier

Date filed (Month, Day, Year)

FEB 26

mont

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c, License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Maryland		artment of rtificate of			giene () Reg. No.	07	00067
	Physici		1. Decedent's Name (First, Middle, Las Mary Lou Russe					2. Date of Dea Month Februa	Dey	Year 200	3. Time of Death 7 6:10 PM
	/Medic Examir		4e. Fecility Name (If not institution, give	street and number)		4b. City, Town,	or Location of D			ity of Death	J. IVICI
			Kline Hospice				nt Airy			eder	
Ĭ.	Funeral Director		220-34-4401	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Yea Months Day		Hrs. 8. Date of Birt Month, Da Mar 16	y, Yeer)		place (State or Foreign ntry) VA
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary Fehr	tor	MD Freder	rick F	Bruns	wick					1XX es 2 □ No
	th the	Director	10e. Street and Number			10f, Zip Code			10g. Citizen o	of What Cou	ntry?
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39	be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "natural", or items 23a or 28a-f ehow event, the Modical Exertiling mail be tratified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No		? (Specify Yes or No uerto Rican, etc.)	Spec	ace - Ameri lack, White,	
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Maryland		Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,		ame)	
7	should be nd Mental marked c	ဥ	Elbert Shumake 19a. Informant's Name/Relationship (7		10h Maili	no Address /Stree	Lei	.la N/F r Rural Route Numbe		m State Ziu	n Code)
Z			Elmer Russell		1			ie, Bruns			
ē,	ges 1 and t of Health If item 27 or other to		20a. Method of Disposition	20b. PI		sition (Name of matory or other p		Date	20c. Location		
altimore,	Pages nent of I int: If it		¹X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Heilioval Ilolii State		ville (F .	eb 28 2007 I	ovett	svil	le, VA
Bait	permit. Page Department Important: if any injury or once.		21. Signature of Funeral S. rvibe Ligen.	see /	1/1/2	2. Name and Add	ress of Facility	Loudoun r.SE,Lee	Funer	al C	hapels
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	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a consequ	ience (i)						
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ō	g Physier this	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			ng Home 5 ☐ Resid			19)
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Division of Vital	ist or Attanding I s after death. st Director: After ed in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, sti	reet, factory, offic	е	28f. Location (S City or Tov	Street and Nur vn, State)	nber or Run	al Route Number,
	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b	edical	(Check only 2 Medical Exem	ysician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	vestigation, in my	opinion, death o	occurred at the time,	date and place	e, and due t	o the cause(s)
	To t com	Σ	29b. Signature and title of certifier		11.5	29c. Lice	nse number	/ /	29d. Date sign		
	*		11000			1	7/8	66	rebruc	ry 2	8,2007
	0		30. Name and address of person who d				D			MD 0	1700
	Sta	ite	Dr. Kanan Hudh 31. Date filed (Month, Day, Year)	ud, MD 46B Th		Johnso	n prive	e, Frede	rick,	MD 2	1/02
44	Regist	3	31. Date filed (Month, Day, Year) 8 2	UU/ PRECES 1	OF A	marke					

State of Maryland / Department of Health and Mental Hygiene. U 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 7:20 AM GEORGE AUGUSTUS RIGHTER 28 FEB /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WESTMINSTER NURSING CENTER WESTMINSTER CARROLL tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 1**X**M 2□F Months 212-20-2125 82 1 Director NOV MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. tnside City Limits ?7 is marked other then "neturel", or iteme 23s or 28s-f ehow traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No MD MONTGOMERY BOYDS Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22930 SHILOH CHURCH ROAD 20841 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 N No If Yes, Give I Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2X No Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AUTO MECHANIC AUTO 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit then of Health and Mental H tent: If item 27 is marked ott jury or other traumatic ever AUGUSTUS REINIER RIGHTER ETHEL MILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET RIGHTER/SPOUSE 22930 SHILOH CHURCH RD., BOYDS, MD 20841 20b. Place of Disposition (Name of STAUFFER Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/1/07 pernit. Page Depentment of Important: If any njury or once. FREDERICK, MD CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner beliners Securitizity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o d a consequence of): Examiner The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 4 hours after death -unerei Director: / investigation 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerei C Hospitai 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print)
688 Poele Rd, Westmin Ster 30. Name an mi 31. Date filed (Month, Day, Year) 32. Pagistrar's Sign State MAR 0 1 2007

DHMH 17 Rev 1/2001

Registrar

07-01795 Gary Richard Rowe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certi	ficate of	Death	a montan	rygione Re	eg. No.	, 0000
Physici		Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
Medical Exami	mer	Gary Richard ROWE 4a. Facility Name (if not institution, give street a	nd number)		h City Town or	Location of Dea	March 7, 2	4c. County of Deat	0532 hrs
		Washington County Hospital	nd namber)	"	Hagerstown		uı	Washington	ın
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Yea	r If Under 24H	rs. 8. Date of Bir	th (MM/DD/YYYY) 9. Bi	rthplace (State or
Director		213-42-1553 1XM 2]F 65	Yrs.	Months Day	s Hours M	Dec. 1	.0, 1941 Fore	gn Puntry) W. Va.
X		Usual Residence of Decedent							
ow any		10a. State 10b. County Maryland Washington		own or Location Hager					10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once,	ctor	10e. Street and Number	•	mager	10f. Zip Code		110	Og. Citizen of What Cou	
ith the Maryland 23a or 28a-f sho notified at once	Director	12 E. Lee Street			2174	40		USA	and y:
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	ral		Decedent Ever in U.S.				Specify Yes or No-		ican Indian, Black,
death or iter	Funeral	Trever Married 2 21 Warred	ed Forces? res 2 X No	If Ye	s, specify Cubar	n, Mexican, Puerl	o Rican, etc.)	White, etc.	
s after raf",	by	3 Widowed 4 Divorced If Yes, Giv or Dates:			Yes 2X No				white
	ted	15. Decedent's Education (Specify only highes Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)	6a. Decedent during mo	s Usual Occupat st of working life	tion (Give kind of . DO NOT use re	work done tired)	16b. Kind of Business	Industry
5-0036 led within 72 Hygiene. other than "	Completed	10	0	pain	ter			city of	Hagerstown
		17. Father's Name (First, Middle, Last)					e (First, Middle, M	,	
2121 wild be fill Mental H marked c event, j	Be	Richard Rowe					beth Fus		
b, MD 21215-0036 and 2 should be filed within 7 teath and Mental Hygene. ten 27 is marked other than traumatic event, the Medica	2	19a Informant's Name/Relationship (Type, Print Virginia L. Rowe – wi	·					ber, City or Town, State Maryland 2	
		20a. Method of Disposition	20b. Pla	ce of Disposit	ion (Name of cer	_	Date	20c. Location - City or	
Baltimore, permit. Pages I an Department of Hea Important: If iten		1 X Burial 2 Cremation 3 Remo	vai iloili otato	matory or other	erplace) n Mem. P	ark 3	/10/07	Hagerstow	n, Maryland
Baltimc permit. Page Department Important: injury or ot		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	7		ame and Address			FUNERAL HON	
ij il De D		3001 11/1/1/1/1/	nne			lson Blv	d., Hage	rstown, Md	
Physician /Medical		23a. Part I. Enter the disease, or complications t failure. List only one cause on each line.	hat caused the death. Do	o not enter the	e mode of dying,	such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner			erosclerotic of as a consequence of):	ardiova	scular dis	sease			Death
		Sequentially list conditions, b.	as a consequence or):						
	ner		as a consequence of):						
178	Examiner	(Disease or injury that initiated C.	as a consequence of):						
ecuted and transi	1	d							
760, cate be executed physician and the burial - transit	Medica	UNPENDED AMEND	FII,27,perME,	g865, 3	3/23/07 TI	[
	Ž	IF FEMALE: 23c. If 23c. If 23c. Was decedent pregnant in the	yes, outcome of pregnar ive birth	ncy	al death 3 [ancv	23d. Date of deliver Month	y Day Year
cath certifications as for use as	sician	1 Vos 2 No 9 Halmaum	regnant at time of death	- =	er (Specify)				
C. Box t the death c by the atten ached for us	Phy	Part II. Other significant conditions contribut	Inknown	Iting in the un	dorlying course o	ivon in Port I	23e Did tol	bacco use contribute to	the cause of death?
ion of Vital Records, P.O. Box 68' trending Physician: The law requires that the death certificath. tor: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as	ā	Chronic alcohol abuse	ing to death but not resu	iting in the ur	idenying cause g	given in Faiti.		2 No 3 Pro	
rds,	Completed	CHIORIC arcoror abuse					24a. Was a		utopsy findings available
e law e has l	mp						autops	med? death?	completion of cause of
tal Rec cian: The l certificate l ector, page	ပိ	25. Was case referred to medical			26.Place	of Death (Check	1 Yes 2	2 No 1 Y	es 2 No
Vita hysicia this ce	O B	examiner? 1 • Yes 2 No	Inpatient 2 EF	NOutpatient	3 DOA	Other Nurs	ng Home 5 F	Residence 6 🗸 Othe	r: Scene
n of ling Pt After funeral	n:	1 Y Natural (Date of Injury 28 Month, Day, Year)	Bb. Time of Inj		ry at Work?	28d. Describe h	ow injury occurred	
	atic	2 Accident Investigation				res 2 No			
Division of Vital Records, uspital or Attending Physician: The law require hours after death. Ineral Director: After this certificate has been siy filled in by the funeral director, page 2 should be the funeral director.	Certification:	Suicide Could not be	Place of Injury - At home	e, farm, street	, factory, office b	uilding, etc.	or Town, St		ıral Route Number, City
file on spi		4 Homicide 29a. Certifier 1 Certifying Physician: To the		death occurre	ed at the time, da	ate and place, an	d due to the cause	e(s) and manner as stat	ed.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the b							
F % F 3	ž	29b. Signature and title of certifier	1 >		29c. Licens			29d. Date signed (Mo	nth, Day, Year)
		Uhlma Branch	MD		0.0.1	VI.E.		March 8, 2007	
d		 Name and address of person who completed Melissa Brassell, MD Assistant 	cause of death (Item 23 Medical Examiner		enn Street R	altimore, MD	21201		
() St	ate	31. Date filed (Month, Day, Year) 3	Registrar's Signature	1					
Regist		MAR 1 4 2007	Colum S.	Spark	20				
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		•	For State Registrar		State	of Ma	ryland				ealth a Death	and M	ental Hy	giene		70	6070
	Physicia		1. Decedent's Name (First, M		st) KYUN	c	SHIN						2. Date of De Month FEBRU	Da		'ear	ime of Death
	/Medic Examin	_	DAVID CHAN 4a. Facility Name (If not institute				DLT TIN		4b. City,	Town, or	Location of	of Death	THEIM		. County of		111
		şille .	9702 WASHIN	GTO	NIAN	BLV					SBUR					GOMER	
	Funeral		5. Social Security Number	6. S	Sex IXIM 2□ F	7. Age		st birthday) Yrs.	Months	Days	If Under: Hours	Min.	8. Date of Bi (Month, D	ay, Year)	936	Country)	State or Foreign OREA
**	Director		229 98 0935 Usual Residence of Deceden			/ (JUNE	1,1	930		
	show	_	10a. State 10b. Cou		MEDIZ			Town or Lo		20							side City Limits
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	with t	٥	10e. Street and Number 9702 WASHIN	rcm0	NIT A NI	BLV	70			0878				US		iat Couriny .	
	death ms 23	Funeral Director	11. Marital Status	GIO	12. Was Dec	cedent E		S. 13. 1			ispanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)		14. Race -	- American Inc White, etc.	dian,
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2	be illed within 72 hours after death with the Maryland Hygiene. do other than "natural", or items 23e or 28e-f show event, it is Mudical Examinar must be notified at	Be	17. Father's Name (First, Mid		•						18. Mothe		(First, Middle DOL	e, Maidei LE)	
7	should nd Men marke umatic	T _o	GAP GIL 19a. Informant's Name/Relat		Type Print)			19b. Mailii	na Addres	s (Street a			I Route Numi			tate, Zip Code	
Z	ulth an	1001	MICHAEL SHI						-				, RO			_	0850
ב מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens became them 28a or 28a-1 show important: Item 27 is marked other than "natural; or items 28a or 28a-1 show eny injury or other traumatic event, the Mudical Examinat must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremat			- Ctata	20b. Pla	ace of Dispo	sition (Na	me of other plac	(8)	C	Date	20c. L	ocation - C	ity or Town, S	State
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00	permit. Departr Imports eny in]	ĺ	21. Signature of Funeral Ser	ice Lice	nsee // a								ARLES			UNERA	
# .	401 G		23a. Part1. Enter the diseas shock, or heart failure.	or con	mplications that	caused	the death						UPPER or respiratory		CTROK	App	20772
**	Physician		Immediate Cause (Final	List only	one cause on	each lin	9.										val Between et and Death
	/Medical		disease or condition resulting in death)	-	a Due to	o (or as a	consequ	ence of.	200	7 / 4	en =	> L					
	Examiner	_	Sequentially list conditions, if any, leading to immediate		b		D	Y5	10	Pi	cf-f	11/1	(a)	<u> </u>			
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9	certificate nding phys use as the	Physiclan/Med	IF FEMALE:		02- 11		-1										
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ν, Γ	requires that the death certificate seen signed by the attending phys hould be detached for use as the	by P	Part II. Other significant cor	ditions	contributing to	death bu	it not resu	Ilting in the u	nderlying	cause giv	en in Part I	۱.				oute to the ca	
cords	w require been si should I							-									4 Unknown
S S	e law has b	Completed											24a. Wa aut	s an opsy formed?	24b. W	eath?	indings available ion of cause of
	page 1	e Co	25. Was case referred to me	dical	T	-					26 Place	e of Deat	1 ☐ Yes	2 X N	0 1[Yes 2	No
<u> </u>	Physician: this certific ral director.	0 B	examiner?	alou.	Hospital:	Inpatie	nt 2 🗆 I	ER/Outpatie	nt 3 🗆 D	OA Oth	or	ursing Ho			6 □Other	r (Specify)	
	r Attending Physician: or death. rector: After this certific by the funeral director.	Du: T	27. Manner of Death	endina	28a. Dat (Mo	e of Injur	y Year)	28b. Time of		28c. Injur Wor			28d. Describe	e how inj	ury occurre	d	
DIVISION	Attending For death.	catl	2 Accident in	vestigation	ho -	on of Ini	ını At bo	me, farm, st	M I		Yes 2		28f. Location	(Street o	and Number	r or Bural Bo	ite Number
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	2 10 8	2	29b. Signature and title of ce	TENIOT -				(.	1	. LICETIS	- Hambel		,	10	ato signed	O s	2 - 1
•	(5)	1	30. Name and address of pe	rson who	completed ca	use of de	eath (Item	23a) (Type	Print)	DI	-DE	1		rvi	evist		1007
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			For State Registrar	State of Mary	rland / Depa <i>Cer</i>	artmer rtifica:	nt of He te of D	ealth and Death	Mental Hy	ygiene Reg. No.	2007	08071
7	Dhysisis	20	Decedent's Name (First, Middle, Last)	_					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Willa Ruth Smit				T		Febru		3, 2007	
	Examin	er	4a. Facility Name (If not institution, give s		+ - x	4b. City		Location of Deat everly	n	1	ince Ge	_
10.00	<u> </u>	.30.	Prince George's Ho 5. Social Security Number 6. Sex		n yrs. last birthday)		r 1 Year	If Under 24 Hrs	8. Date of B		9. Birt	hplace (State or Foreign
	Funeral Director	Α.		M 20 F 70	Yrs.	Months	Days	Hours Min.	8. Date of B	36 Year)	colî	ege Pk.,Md.
g	> 1000		Usual Residence of Decedent	14	oc. City, Town or Lo	cation						10d. Inside City Limits
lanyla	ehov	7	10a. State 10b. County		Collec		rk					12 Yes 2 No
the N	28a-f	ect	Md. P.G.		OTTE		p Code			10g. Citi	zen of What Co	untry?
with	3a or	ā	8124 48th Avenue	2				20740			U.S.	Α.
3-UU30 72 hours after death with the Maryland	run	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Dece	edent of His	spanic Origin? (5 n, Mexican, Puer	Specify Yes or No Rican, etc.)	10-	14. Race - Ame Black, White	
after	or th	F	1 Never Married 2 Marned	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 🗆 Yes	_	Specify:	,,			Black
3-UUSO 72 hours af	ural',	d by	3 Widowed 4 Divorced		16a. Dece	dont's He	ial Occupa	tion		16h Ki	nd of Business/	Industry
6 13	"nal	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	kind of w	ork done di use retired)	uring most of wo	rking	100.10	114 01 243	
A With	r ther	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	Diet	ticia	n			Uni	v. Of M	aryland
d be filed	other vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Na			Sumame)	
	Menta arked aric e	D C	George Smith						a Mae P			
Mar d 2 sh	Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or items 23s or 28s-f ehow any injury or other traumatic event, tra Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty. Ivy G. Briscoe/Dat			_		nd NumberorR l Ct.,Ch				
6, 1	Health em 27 thar t	1	20a. Method of Disposition		20b. Place of Dispo cemetery, crei				Date	-	ocation - City or	
nor ages	t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Oueen's				3/2/0	7 Rel	tsville	- Md -
SAITIMOF	ortan ortan injur	1	21. Signature of Funeral Service License					s of Facility ashingto		- ^-		, pract
n a	Depa Impo any ir) gany N	. Grat	ī	4925	Burro	oughs Av	e.,N.E.	,Wash	ington,	D.C. 20019
Sea.			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	e death. Do not en	ter the mo	de of dying	, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
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uted	ansit	Examiner	Cause (Disease or injury									
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OX OB/OU, certificate be executed	attending physicien and for use as the burial-transit	dicai	C.	ı								
	ling pl	Med	IF FEMALE:	20 Maria cutores of								
Geath cer	attend for us	Physician/Me	in the past 12 months?	3c. If yes, outcome of 1 Live birth 2 [4 Pregnant at tin	Fetal death 3	⊒Ectopic ⊒ Other (s	pregnancy				23d. Date of de Month	Day Year
j g	y the ched	ysic	1 □ Yes 2 No 9 □ Unknown	9□ Unknown	16 OI G64(II - 5)							
That The C	been signed by the s	by Pr	Part II. Other significant conditions con	ntributing to death but r	not resulting in the u	underlying	cause give	n in Part I.	23e. Di	d tobacco i	use contribute lo	o the cause of death?
Ords,	on sign								1[Yes 2	Mo 3□Pi	robably 4 Unknown
VITAI RECORDS	s bee	Completed							24a. W	as an topsy	24b. Were at	utopsy findings available completion of cause of
Ž P	ete h page	E O							pe 1 □ Yes	rformed?	death?	2 □ No
/ ita	is certificete director, pag	Be (25. Was case referred to medical examiner?				Oth .		eath (Check onl	y one)		
OT Physic	this c	2	1 Li res 2/27NO	1 Inpatient 28a. Date of Injury	2 ER/Outpatie			4 Nuising	Home 5 ☐ Re		6 Other (Spe	ecify)
	h. After funer	tion	27. Manner of Death 1	(Month, Day Y		M	28c. Injury Work	rai Yes 2 □ No	200. 0030112	o now inju	ry occurred	
DIVISION Of VITA Prysician:	after death. I Director: A d in by the fu	fica	3 Suicide 6 Could not be	28e. Place of Injury	Al home, farm, sl							ural Route Number,
= 5	. ± ± €	Certification:	4 Homicide	building, etc. ((Specify)				City or i	Town, State)	
Hospital	within 24 hours a To the Funaral E completely filled	edicai (29a. Certifier (Check only bne) (Check only bne) (Check only bne)	sician: To the best of a ner: On the basis of ea and manner state	kamination and/or in	th occurre	d at the tim on, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the tim	ne cause(s e, date and) and manner a d place, and du	s stated. e to the cause(s)
To the	o the	Med	29b. Signature and title of certifier	and marrier state	10	2	9c. License				te signed (Mon	th, Day, Year)
-	· s i o		1 mills) " /	NO-		D41	715		2/24	4/07	
Ks	2)		30. Name and address of person who a	pleted cause of dea	th (Item 23a) (Type	, Print)						
5)/		Chitra Venkatram				Rd.# 1	U#3,Coll	ege Par	k,Md.	20740	
		ate rar	31. Date filed (Month, Day, Year) FEB 2 8 2007	32. Registrar's	s Signature	•						

07-01663 Ge

Amended Item 5 per F.D. 03/07/2007 Carroll County, wjl

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eraido Gorizai	ez.	State of Mai	ryland		rtment d tificate d		na ivientai	Hygiene		200	7 0007
Physici	on/	Registrar 1. Decedent's Name (First, Middle,Last)			incate	Deau		2. Date of De	Reg. No	Research Con'	3 Time of Death
edical Exam		Gerardo Gonzalez	Se	rranc)			Month March 2,	Day	Year	0607 hrs
		4a. Facility Name (if not institution, give street an	d number)			or Location of De	ath		c. County of Deat	1
·		Frederick Memorial Hospital 5. Social Security Number 6. Sex	17.40	o (la uso la	ot bidbdoo	Frederick	000 IÉLI-de-041	In In Date of B		Frederick	dhalasa (Chata
Funeral Director					ast birthday)	Months D		Ain.	·	I/DD/YYYY) 9. Bi	gn
		Unknown 1 X M 2 Usual Residence of Decedent	JF	47	Yı	rs.		Apr.	24,	1959 ^{cc}	^{Duntry} CostaRica
any		10a. State 10b. County		10c. City,	Town or Loca	ation					10d. Inside City Limits
and show	'n	Maryland Frederick				Ke	ymar				1 Yes 2 XNo
Maryl -28a-1	Director	10e. Street and Number				10f. Zip Code			_	tizen of What Cou	-
with the Maryland ms 23a or 28a-f show be notified at once		12017 Legore Bri					21757			osta Ric	
ath with the items 23a	Funeral	1 Never Married 2 X Married Arms	ed Forces				Hispanic Origin? (an, Mexican, Pue		0-	14. Race - Amer White, etc.	ican Indian, Black,
fter de l'', or		3 Widowed 4 Divorced If Yes, Give		X No	1 2	Yes 2	No specify: CC	sta Rica	an	Specify: Hi	spanic
ours a atura xamin	d by	15. Decedent's Education (Specify only highest	grade cor	npleted)	16a. Decede	ent's Usual Occup	pation (Give kind of	of work done		Kind of Business	
16 n 72 h an "n ical E	lete		ge (1-4 or	5+)			machine	lettred)			
within giene her the Med	Completed	17. Father's Name (First, Middle, Last)			mecha		perator	me (First, Middle		dairy fa	irm
115- e filed al Hyg eed off	Be C	-tsrael Castillo				unk	•	anda Gon:			
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene n 27 is marked other than numatic event, the Medica	TOE	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Str				City or Town, State	e, Zip Code)
s, MD 21215-0036 and 2 should he filed within 72 hours after death with the Maryland teath and Mental Hygiewei with 72 hours after death with the Maryland teath and Aris marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner, must be notified at once	1	Ines Vargas/ wife					Bridge			r, MD 21	
altimore, rmit. Pages I an apartment of Hea ipportant: If ite		20a. Method of Disposition 1 Burial 2 X Cremation 3 Remove	al from St		Place of Disponentation of the contract of the	sition (Name of other place)	cemetery,	Date	20c.	Location - City or	Town, State
Lime Page Iment Taut:		4 Donation 5 Other Specify:		A11	l Coun	ty Crema	tion 3/	/6/2007	5	Sykesvil	e, MD
Baltimore, MD 21215-0036 Depenit. Pages 1 and 2 should hefiled within 72 hours afte Department of Health and Mental Hygie weit in Inportant: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	l j	2) Santan of Funeral Service Licensée	lan	/	22.	Name and Addre	ess of Facility Ha	artzler	Fune	ral Home	200
Physician		23a. Part I. Enter the disease, or complications the	nat caused	the death.		04 S. Ma the mode of dyir				MD 2179 lock, or heart	Approximate Interval
/Mr dical	(Q. 7)	failure. List only one cause on each line. Immediate Cause (Final disease a. Ather	oscle	rotic c	ardiova	scular dis	sease				Between Onset and Death
Examiner				equence of							
	Į.	Sequentially list conditions, if any, leading to immediate Due to (or	as a cons	equence of	f):						
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated									
ited d ansit		events resulting in death) Last Due to (or d.	as a cons	equence of	7):						
executed ian and ial - transit	Physician/Medical		EB)7 7	erME, g	-865 3/	23/07 TT	#1,perME,	17 portU			
760, cate be physic he bur	Med	IF FEMALE: 23c. If y	es, outco	me of pregr	nancy	23/07 11	#1,perms,	17, perrn		3d Date of deliver	y
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Box 68760, death certificate be the attending physic df for use as the bur	ysic	1 Ves 2 No 0 No 1 Holosous H	Inknown		2 [] (other (Specify)					
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be certificate has been signed by the attending physici ector, page 2 should be detached for use as the buri	by Pr	Part II. Other significant conditions contribution	ing to deat	th but not re	sulting in the	underlying caus	e given in Part I.				the cause of death?
S, P uires th n signe Id be d	ed b										bably 4 Unknown
ord tw req as bee	plet							24a. Wa		prior to	utopsy findings available completion of cause of
Rec The la ficate h	Completed							1 🗸 Yes		No 1 Y	es 2 No
Eivision of Vital Records, To the Hospital or Attending Physician: The law required that the hospital or Attending Physician: The law required the hospital of the Funeral Director: After this certificate has been sompletely fill, d in by the funeral director, page 2 should the hospital or the hospital director.	Be	25. Was case referred to medical examiner? Hospital:	Inneti	ant 2 4	ER/Outpatie		Other	ck only one)	Posid	ence 6 Othe	
of Vit ing Physic After this uneral dire	5	1 Ves 2 No 28a.	Date of Inj	ury	28b. Time o	1,	njury at Work?			jury occurred	1.
On C ending ath or: Af he un	tion	1 X Natural 5 Pending	Month, Day,	Year)		1_	Yes 2 No				
Division rate of a process of a Director:	ifica	2 Accident Investigation 3 Suicide 6 Could not be	Place of I	njury - At ho	ome, farm, str	eet, factory, offic	e building, etc.	28f, Location or Town,		and Number or R	ural Route Number, City
pital ours a nera I	Certification:	4 Homicide determined (Spe	ecify)					J. John,	Oldio)		
Di To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier (Check only one) 2 Medical Examiner: On the b.	e best of m	ny knowled emination a	ge, death occ nd/or investig	urred at the time,	date and place, a	and due to the car ed at the time, dat	use(s) a e and pl	ind manner as sta lace, and due to t	ted. ne cause(s)
To the withing To the comp	Medical	29b. Signature and title of certifier	ner stated	-			nse number			Date signed (Mo	
N	_	7/ 1/2	10				C.M.E.			rch 3, 2007	
MIL		30. Name and address of person who completed	cause of	death (Item	23a)				J		
		Zabiullah Ali, M.D. Assistant Me				nn Street, B	altimore, MD	21201			
s	tate	31. Date filed (Month, Day, Year) 3	2. Registra	ar's Signatu	ire						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Hildegard Paula Solimando February 22, 2007 0852 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 875 Snowfall Way Carroll Westminster If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F Yrs. Director 216-28-7293 82 Apr 15, 1924 Germany Usual Residence of Decedent deeth with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2000 Directo Maryland Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 875 Snowfall Way 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No Ś Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be nent of Health and Mentel int: if item 27 is marked o Karl Nesch Bertha (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim B. Dulik Daughter 1652 Benson Rd. Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☐ Burial 2☐Cremation 3 ☐ Removal from State important: if eny injury o once. 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc: 2/23/07 Hampstead, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Savio Licens 412 Washington Rd. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to as a consequence of): Examiner 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ettending physicien and for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) certificate hes been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 7 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 1/2 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation hours efter deal 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours el To the Funeral D completely filled in To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) 29c. License number 20

Registrar DHMH 17 Rev 1/2001

State

30. Name and

dress of person

FEB 2 6

200

31. Date filed (Month, Day, Year)

288 Pook Rd, Wu

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CettonunD

		•	1 - For State Registrar	State of	Marylan	•	artment of Hertificate of E			ene g. Ng2 () () 7	08074
	Physici /Medic		Decedent's Name (First, Middle, David Edv.	•					2. Date of Death Month	Day Year	1
	Examir		DOVE HOUSE	rroll H			4b. City, Town, or Westmi			4c. County of De	
	Funeral Director		218-58-5633	1 ⊠ M 2□F	55		Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov 23,	1951 Ma	ryland
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County Maryland Carre	~11	10c. City	y, Town or Lo		stminste	r		10d. Inside City Limits 1
:	death with the Maryland ms 23a or 28a-f show Friust be mullited at	Funeral Director	Maryland Carro 10e. Street and Number 54 Liberty Street		2		10f. Zip Code	21157		g. Citizen of What C	Country?
		by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 12 Widowed 4 □ Divorced	12. Was Dece Armed For	dent Ever in U. rces? 2 MNo e		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (S) n, Mexican, Puerto Specify:	pecify Yes or No- D Rican, etc.)	14. Race - An Black, Wh Specify:	
20-6171	be tiled within /2 hours affer tal Hygiene. Id other than "natural", or its event, the Medical Examina	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	Education		(Give	dent's Usual Occupa kind of work done di DO NOT use retired) Seaman	uring most of wor	king	6b. Kind of Busines	
ומונת ע	ild be tiled lental Hygie ked other itc event, II	To Be Co	17. Father's Name (First, Middle, La Andrew Louis			<u> </u>			ne (First, Middle, M e Marie B		
_	and 2 should ealth and Men n 27 is marke ler treumatic		19a. Informant's Name/Relationship Judith A. Strei		-		Athold @Ro				
	rages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		State Soil	emetery, crei JTD	esition (Name of matory or other place	02/2	Date 2 4/2007	Oc. Location - City of Winfield	
000	Deportr Imports any inju	1	21. Signature of Funeral Service Lie	Sensee N	401191		2. Name and Address 91 Willis				
	Physician /Medical Examiner	ner	23a. Part). Enter the disease, or or cachetic, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditione, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	IV one cause on ea	ach line		er the mode of dying				Approximate Interval Between Onset and Death
,0070	ate be execute thysicien and the burial-trans	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (i	or as a consequ	uence of):					
O. DOX 0	to the hospital or Attending Prhysicien: The law requires that the death certificate be executed within 54 brouss efter death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
Ords, P.	quires that the same of the sa	5	Part II. Other significant condition		BRILL			n in Part I.	23e. Did toba		to the cause of death? Probably 4 □Unknown
	: Inelaw re cate has ber . page 2 sho	Completed							24a. Was an autopsy perform	prior to ed? death?	autopsy findings available completion of cause of es 2 No
S :	rnysicien: rthis certific ral director.	9 Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital:	npatient 2	ED/Outpoties	1000		th (Check only one		
	nding Pny ath. r: After this e funeral d	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of	of Injury h, Day Year)	28b. Time o Injury	f 28c. Injury Work	- Indiangin	28d. Describe how		ecity) Hospice
בואוצ	the Hospital or Attending in 24 hours effect death. the Funeral Director: After pletely filled in by the fune	Certification;	3 Suicide 6 Could no 4 Homicide determine	28e. Place building	of Injury - At ho ng, etc. (Specif)	ome, farm, str	eet, factory, office		28f. Location (Streetly or Town,		Rural Route Number,
:	n 24 hour n 24 hour ne Funsra	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the aminer: On the ba and mann	isis of examinat	wledge, deat tion and/or in	h occurred at the time vestigation, in my op	e, date and place inion, death occu	, and due to the car rred at the time, da	use(s) and manner te and place, and di	as stated. ue to the cause(s)
1	within comp	Me	29b. Signature and title of certifier	Afre	erces (20 m	29c. License			d. Date signed (Mod	
	5	O S	30. Name and address of person	mpleted cause	e of death (Item	За) (Туре,	Print) 4	147 E	AST N	SAIN S	97 7. D. 21157
4	Sta Registr		31 Date filed (Month, Day, Year)	2007 32. Re							

Amended Item 19b per F.D. 02/26/2007 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Maryland	/ Dep		t of H	ealth a		ental Hyg	iene	0.7	08075
	1 TE-4		Registrar 1. Decedent's Name (First, Middle,	[ast]							2. Date of Dea			3. Time of Death
п	Physici	an									Month Februar	Day 27	2007	10:00 PM
N.	/Medic		Arnold Sc 4a. Facility Name (If not institution,	hein	or)		4h City	Town or	Location of		rebruar	1	ty of Death	
7	Examin	er					,			,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Frede	
		- 4	Sunrise Retire		Age (In yrs. la	st birthday	1 1 1 1 1 1	eder:	If Under	24 Hrs.	8. Date of Birth (Month, Day		9. Birth	place (State or Foreign
	Funeral Director		072-14-5087	1⊠M 2□F	83	Yrs.	Months	Days	Hours	Min.	Month, Day, April 3	1923	Cou	York
			Usual Residence of Decedent		- 05						-p	,		
	yland		10a. State 10b. County		10c. City,	Town or Le	ocation							10d. Inside City Limits
	Mar	tor	Maryland Carro	L1		Mou	ınt Ai	ry						1 ☐ Yes 2 점 No
	r 28s	Irec	10e. Street and Number				10f. Zip	Code			1	0g. Citizen o	f What Cou	intry?
	h wit	a D	6290 Twin Pond	s Lane				2	1771			Un	ited	States
	deat	ner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S	13.	Was Deced	dent of H	ispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	14. R	ace - Amer lack, White	ican Indian, , etc.
9	or its	Fu	1 Never Married 2 Marrie	d 1 X Yes 2	□No		1 🗆 Yes					Spec	oify:	White
8	within 72 hours after death with the Maryland sne then "naturel", or items 23s or 28s-f ehow its Madical Exeminer must be notified at	Completed by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	Year or Date	ss: WWII								5	
5-	72 h natu	ete	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usua kind of wo DO NOT us	rk done	durina mos	t of workir	ng	16b. Kind of	Business/1	ndustry
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2	lled v tygie her t	ပိ	12 17. Father's Name (First, Middle, L	251)			Agei	111/			(First, Middle,			ilee
anc	tall be for	Be								Ida	,	Unkn		
Ž	Jarke nark	ို	Roger J. Schei 19a, Informant's Name/Relationshi			10h Mail	ing Address	(Street	and Numbe		l Route Numbe			in Code)
Maryland 21215-0036	12 st h and 7 ie n traun						_				it. Airy			
6,1	1 and Healt em 2 ther		Paul Schein / 20a. Method of Disposition	Son	20b. Pla	ace of Disp	osition (Nar	ne of		D	ate	20c. Locatio		
ō	in it of h		1 ☑ Burial 2 ☐ Cremation		ate ce	metery, cre	matory or o	ther plac	1 .	March	1	11	M	1 4
ij	tmer tant dury		4 Donation 5 Other (Sp.		Jud	ean G	arden: 2. Name ar			2, 20		Olney,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 ie marked other then "nature!", or iteme 23a or 28a-f ehow emportant: if item 27 ie marked other then "nature!", or iteme 23a or 28a-f ehow my jury or other traumatic event, the Medical Exeminar must be notified at once.		21. Signature of Fuperal Service L	120	-	8	E. R:	idge	ville	B1vc	d. Mt.	Airy,		es, P.A. land 21771
		Ì	23a. Part1. Enter the disease or shock, or heart failure. List of	omplications that cau nly one cause on eac	ised the death. th line.	. Do not en	iter the mod	ie of dyin	ig, such as	cardiac o	r respiratory ari	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Pneum	nonia									Day
	/Medical		resulting in death)	Due to (or	as a consequ	ence of):								
	Examiner		Sequentially list conditions.		nce Dem		Fron	tal	Lobe					Years
	י ש	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	4	as a consequ									37
	ocute ind trans	am	that initiated events resulting in death) Last	U	tensio				_					Years
760,	e exe	Ä	resulting in death) cast		as a consequ									Years
6876	cate b	dlcal		d Hyper	lipide	mıa								lears
Box 6	requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the buriat-transit	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnan		□Ectopic pi	ragnano.					Date of deli	,
	wrequires that the death been signed by the atte should be detached for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of de		Other (sp						Month	Day Year
P.O.	t the by th	hys	9 Unknown	9LI UNKNOW	m 									
	s tha	y P	Part II. Other significant condition	s contributing to deal	th but not resu	Iting in the	underlying o	ause giv	en in Part I	l.				the cause of death?
rd	quire an sig	edt	Hypothyroid, Di	abetes,							1 □ Y	es 2 🛭 No	3 □ Pro	obably 4 Unknown
Division of Vital Records,		plet	Renal Insuffici	ency, Hypo	albumu	n					24a. Was a autop		b. Were au	topsy findings available completion of cause of
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tal	iicien: Th certificete rector, pag	Bec	25. Was case referred to medical						26. Place	e of Death	(Check only o			
>	ding Physicien: h. After this certific funeral director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inp	oatient 2 🗆 E	ER/Outpatie	ent 3 D	Oth	er: 4 🗆 Nu	ursing Hor	me 5□Resid	ence 6 🖾 🤆	Other (Spec	Assisted hy)Living
0	g Ph ier th ieral		27. Manner of Death	28a. Date of (Month,	Injury Day Year)	28b. Time Injury	of a	28c. Injur Wor	y at k?	-	28d. Describe h	ow injury occ	curred	
0	utending death. ctor: After y the funer	atlo	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investig	ation		,,	М	1 🗆	Yes 2	No				
Vis	Atte	if ic	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	and 288. Place of	f Injury - At hou	me, farm, s	treet, factor	y, office			28f. Location (S City or Tow		mber or Ru	ral Route Number,
D	s afte	Certification:			,, 010, (0,000),	, 								
	ospit hour uners ly fills		29a. Certifier 1 Certifying (Check only 2 Medical E	Physicien: To the bexeminer: On the bas	est of my know	viedge, dea	th occurred	at the til	me, date ar	nd place, a	and due to the o	ause(s) and	manner as	stated. to the cause(s)
	To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	and manne		and of								
	To t To t	Σ	29b. Signature and attle of certifier	· Wall	1	MA	29		e number		1	_		n, Day, Year) 8 2007
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0	TIVE		30. Name and address of person v								,	3.6	1 1	01701
7	>'		Allen Reilly,		Tol1		e Ave	nue	D-1	Fre	ederick	, Mary	⊥and	Z1/U1
		ite	31. Date filed (Month, Day, Year)	32. R	histrar's Signat	ure	land.							
	Regist	rar	FFB 2	R 2007	du ,	U A	DEALL							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. __ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Clara Scott February 23, 2007 8:15 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1000 Heather Ridge Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Year) 1 □ M 2 13 TF 90 1917 Director 579-26-2875 15, January Maryland Usual Residence of Decedent 10c. City, Town or Location show 10a, State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f showed: all Exminer must be notified at Frederick Yes 2□No Maryland Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Heather Ridge 21702 USA permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Exminger must Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black. þ Specify. Specify: 3 √ Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Domestic worker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Marshall Smallwood Lillie Mae Weedon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Whims - daughter 1000 Heather Ridge, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Cemetery 3-2-2007 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician ancrea CHILO disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has autopsy performed? The certificate or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ Mo Be 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Prnys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

Thomas

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Hudhud, MD 468 Thomes

32 Registrar's Signature

31. Date filed (Month, Day, Year)

FEB 2 8 2007

Johnson Drive Frederick

			For State	State of M	arylan		artment of F		nd Me		-	ann.	1 086	777
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	- Cale Of	Dealli	1 2	R. Date of Dea	eg. No. 🤇 th	_ 0 0	3. Time of	Death
П.	Physici		Edwin	B.	Sir	dair	_			Month 3	Day	a oo	200	
**************************************	/Medio		4a. Facility Name (If not institution,	give street and number)		0,0-1	4b. City, Town, o	r Location of	Death		4c. C	ounty of De		
			Coastal Hosp	ice at the	Lak	2	Salist	burg				Wico	mico	
	Funeral		5. Social Security Number	3. Sex 7. Ag 1 X M 2 ☐ F		ast birthday)	If Under 1 Year Months Days	If Under 2	Min. 8	. Date of Birth (Month, Day)	Year)	9. Bi	rthplace (State or	Foreign
als	Director		212-28-8833 Usual Residence of Decedent	'A''	75	Yrs.			0	8-21-1	931		ryĺand	
Puc C	at ow		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside Cit	y Limits
No.	fled sh	ţŏ	MD Somerse	et	Pr	incess	. Anne						1 ☐ Yes	2 No
4	a or 28a-f show	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	n of What C	ountry?	
t i	23a ust b	ral	12531 Palmetto	Church Roa	d		21853				Į	JSA		
000	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specif Puerto Ric	y Yes or No- can, etc.)	14	Race - Am Black, Wh	erican Indian, ite. etc.	
d 21215-0036 filed within 72 hours offer death with the Mandard	", or i	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 💢 If Yes, Give Year or Dates:	No		I□Yes 2⊠No	Specify:			s	Specify:		
3	atural sal Ex	ed b	15. Decedent's			16a. Deced	lent's Usual Occup	ation			16h Kinc	of Business	White	
1215-0036	Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5.1	(Give life. L	kind of work done of NOT use retired	during most (d)	of working			0. 2001100	or made try	
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and Tabe file	ntal Hygiene. ed other than "natural", or items 23a event, the Medical Examiner must I	Be (17. Father's Name (First, Middle, La	,				18. Mother	's Name (F	First, Middle, I				
Va	h and Mental Hygie 7 is marked other traumatic event, th	ဥ	Lloyd Barton Si							lia Roy				
Mar	of Health and Mer If Item 27 is marke or other traumatic	0.0	19a. Informant's Name/Relationship				g Address (Street							
ָּבְּי (פּ	Health em 27 ther tr		Dorothy Ruth Si	inclair/Wif		12531	Palmetto	<u>o Chur</u>	ch Ro				ne, MD 2	<u> 1853</u>
	t: If It		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				sition (Name of natory or other place Family Ce					•	•	
barrimore,	Department of Healt Important: If Item 2 any injury or other once.		2) Signature of Funeral Service Lie		JOIN		. Name and Address nman Fund			/2007 1	rinc	ess A	nne, MD	
מ מ			MODE WILL	Mach Mou	0295		nman Func 673 Some			Prince		Anno	MD 2105	2
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused	d the death	. Do not ente	er the mode of dyin	ng, such as ca	ardiac or r	espiratory arre	est,	Anne	Approximate Interval Betw	
Pl	nysician		Immediate Cause (Final disease or condition	Metas	tatio	- 1	runa	Canl	or	_			Onset and D	eath
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ted	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence or):								
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riffica	ng ph as th	/ledi	IE ECMAL C.											
X Oct	tendii or use	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	pf pregnar 2 □ Fetal		Ectopic pregnancy	,			23	d. Date of de		
j e	the ar	Physician/Me	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of de		Other (specify)					Month	Day Y	ear
That #	ed by detac		Part II. Other significant conditions	s contributing to death b	ut not resul	ting in the un	derlying cause give	en in Part I	-	23e Did toh	acco use	contribute t	o the cause of de	ath?
v requires t	signe Id be	d by		3			give			Ye Ye			robably 4 🗆 U	
	shoul	lete						-	- 1	24a. Was ar				
F Pe	e has	Completed					- 4 1.		_	autops perform	y 1	prior to death?	utopsy findings a completion of ca	use of
an:	rtificat tor, p	a	25. Was case referred to medical					26 Place o	of Death (C	1□ Yes Check only one	No No	1	s 2/2/No	
y v	direc	To B	examiner? 1 ☐ Yes No	Hospital: 1 Impatie	ent 2 🗆 E	R/Outpatient	3 DOA Othe	251		5 ☐ Reside		□Other (Spe	ecify)	
ding P	offer the		27. Mapher of Death Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year)	28b. Time of Injury	28c. Injury Work			I. Describe ho				
tendi	tor: A	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he				Yes 2 □ No						
o A	Direc Direc in by	Certification:	4 Homicide determine	28e. Place of injuding, et	c. (Specify)	ne, rarm, stre)	et, factory, office		28f.	Location (Sti City or Town	reet and I , State)	Number or Fi	ural Route Numb	er,
spita	neral / fillec		29a. Certifier Certifying	Physician: To the best	of my know	/ledge, death	occurred at the tin	ne, date and	place, and	d due to the ca	use(s) ar	nd manner a	s stated.	
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only / 2 Medical Ex	caminer: On the basis o and manner sta	t examinati	on and/or inv	estigation, in my o	pinion, death	occurred	at the time, da	ate and p	lace, and du	e to the cause(s)	
5	To t	Σ	29b. Signature and title of certifier		1		29c. License	number	70	25	d. Date s	signed (Mon	th, Day, Year)	
			AUC) MI)	Do	621	8		9-	2-0)	
			30. Name and address of person wh	no completed cause of d	+11	23a) (Type, F	e DO F	30x 17	733	Solis	ch	MO	2180	2
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra		ure	- / - 6	1.10	-	<u> </u>)	000	
	Registr	ar	MAR 0 5	2007	Sean o	K.	don't .							

ORIGINAL

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			1 - For State Registrar	State of M	arylan		artmen rtificat				ntal Hy	/gien Reg. N	21111	7	03078
	Dhusiaì		1. Decedent's Name (First, Middle, L.	ast)							Date of D Month		ay Y	'ear	3. Time of Death
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1	Examin	er	4a. Facility Name (If not institution, gi			_				of Death			c. County of Cecil		
	Funeral		Calvert Mano 5. Social Security Number 6.	Sex 7. Ac		ast birthday)	If Under	1 Year			Date of B). Birthp	lace (State or Foreign
in the second	Director		128-03-4186	1 □ M 2 🛣 F	39	Yrs.	Months	Days	Hours	Marc Marc	h 6,	19	18 1	Vew	York
	pu s		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							1	0d. Inside City Limits
	Maryla f eho	ō	MD Cecil			rth E									1 Yes 2 No
	r 28a-	rect	10e. Street and Number				10f. Zip					10g. C	itizen of Wh	at Coun	itry?
	th with	alDi	328 Hances Po	int			21	901-	-533	33		U.	S.A.		
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow fre Medical Examirant Remodified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	,	S. 13.	Was Deced	dent of Hi cify Cuba	ispanic C in, Mexic	rigin? (Specifi an, Puerto Ric	y Yes or Nan, etc.)	lo-	14. Race - Black,	Americ White,	
36	s afte	ьу Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Xivorced	1 ☐ Yes 24 If Yes, Give Year or Dates:	No		1 🗆 Yes	X □ No	Specif	y:			Specify: V	Whi	te
Maryland 21215-0036	thour stural	ed t	15. Decedent's 8	ducation		16a. Dece	dent's Usua	al Occupa	ation			16b.	Kind of Busi	ness/Ind	dustry
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and	be filed htal Hygie od other event, t	Be	17. Father's Name (First, Middle, Las Frank Wagner	t)						her's Name (F 1known		e, <i>Maid</i> e	in Sumame)		
2	should ind Men marke umatic	٩	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	na Address	(Street a	and Num	ber or Rural F	Route Num	ber, City	or Town, St	ate, Zip	Code)
Ma	nd 2 s lith an 27 le i		Judy Squire		r)	328	Hanc	es I	Poir	nt, No	rth	Eas	t, MI	2	1901 - 5333
re,	item othe		20a. Method of Disposition			lace of Dispo emetery, cre	osition (Nar	ne of other place	(a)	Dat	9	20c.	Location - Ci	ity or To	wn, State
<u>m</u>	Page nent c ant: If ary or		1 Surial 2 Cremation 3			. Sha				3/9/2	007	Spr	ingf	iel	d, PA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinating indicating any injury or other traumatic event, it a Medical Examinating indicating any once.		21. Signature of Funeral Service Lice	ensee		<u> </u>	2 SCH 19 P	deni hila	séfg ade I	^{lity} Memo phia	rial Pike	, Ch	apel ilm.,	, DI	E 19809
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· ski	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):									
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x 68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	/Med	IF FEMALE:	23c. tf yes, outcome	of pregna	Incv							23d. Date	of deline	20/
Вох	atten atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	death 3	Ectopic p						Month		Day Year
P.O.	t the d by the ached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown											
	The taw requires that the take been signed by the bage 2 should be detache	by P	Part II. Other significant conditions			-	inderlying o	ause give	en in Par	t I.					ne cause of death?
ord	equire en si ould t	ted	PENIPHERAL 1	ASCULACI)	3EVZE						1] Yes	2 X No 3	☐ Prob	ably 4 Unknown
ecc	has be	Completed	PARKINSONIS								24a. Wa aut	s an opsy formed?	pric	ere auto or to cor ath?	psy findings available mpletion of cause of
E H	cate h										1 ☐ Yes				2 No
Vital Records,	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		50/0		Oth	or:	ce of Death (C 🗆 Oth	/C/	
	Phys or this oral dii	-	1 ☐ Yes → No 27. Manner of Death	28a. Date of Inju	ıry	28b. Time of		28c. Injun Worl		Nursing Home			ury occurred		<i>(</i>)
ion	Attending in death.	ation	↑XNatural 5 ☐ Pending 2 ☐ Accident investigati	on (Month, Da	ay Year)	Injury	М		K? Yes 2[□No					
Division of	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not determine		jury - At ho tc. (Specifi	ome, farm, st	reet, factor	y, office		28	Location City or T			or Rura	l Route Number,
Õ	ital or irs afte ral Dir														
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai		hysician: To the best iminer: On the basis of and manner st	of examina										
	ithin 2 o the	Med	29b. Signature and title of certifier	and manner s	ated.		29	c. Licensi	e numbe	r		29d. D	ate signed (Month.	Day, Year)
)	⊬≯≓ŏ		Kom IXA]	453	419			MA	nc47	, 20	07
	Δ		30 Name and address of person who	completed cause of	death (Iten	1 23а) (Туре,		,		C	M ~			-	
	9		Kooney Dodinar	1 Day 139	31 TE	9 consis	ARM	D K	15xch	200	U	29	11		
22	Sta Registr		31. Date filed (Month Day, Year) 20	o completed cause of 139	rar's Signa	ture	Ser.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				rtificate of Death	ntal Hyglene Reg. No. 2 0 0 7 0 0 7 0
	Physic	ian	Decedent's Name (First, Middle, Last) Cophic Markey Thrighty against the second		Date of Death Month Day Year 3. Time of Death
	/Medi Examii		Sophie Marcus Triebwasser 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ebruary 25, 2007 2:30 AM
	ZAGIIII		Genesis Eldercare Severna Park	Severna Park	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 100–14–9731 1 M SEF 83 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Year) July 6, 1923 9. Birthplace (State or Foreign Country) New York
	and ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lor		10d. Inside City Limits
	ne Maryl 8a-f sho ptified a	ctor		Annapolis	10d. Inside City Limits
	ath with the 23a or 23 ust be no	Funeral Director	319 Carriage Run Road	10f. Zip Code 21403	10g. Citizen of What Country? U.S.A.
980	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at			Vas Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ric ☐ Yes 2 ☑ No Specify:	y Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	hin 72 ho e. an "natur Medical I	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give life. Deceded) Elementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation kind of work done during most of working OO NOT use retired)	16h Kind of Business/Industry
21	e filed wit al Hygiene other the vent, the	Com	12	Homemaker	Own Home
land	ould be fil Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last) Morris Marcus		First, Middle, Maiden Surname) (unknown)
Maryland	N -				Route Number, City or Town, State, Zip Code) Annapolis, Maryland 21403
Baltimore,	of of			sition (Name of Date natory or other place)	
tim	t. Pa rtmen rtant: rjury		4 Donation 5 Other (Specify) Baltimore	Crematory 2/28/2	8007 Baltimore, Maryland
Ba	permi Depa Impo any is		21. Signature of Funeral Service Licensee 22. 14 23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	7 Duke of Glouceste	M. Taylor Funeral Home or St., Annapolis, MD 21401
	Physician /Medical Examiner	L	aspiratory arrest, Approximate Interval Between Onset and Death		
68760,	rificate be executed og physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):		
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rds, P	requires that the de een signed by the a nould be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
al Records,	The law ate has b page 2 sh	Completed			24a. Was an autopsy performed? 1 \(\text{Yes} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No
or Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (C	
on or	ding Pt After tr funeral	-16	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Thursing Home	5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred
Division	p 4 € =	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, streed building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investant and manner stated.	occurred at the time, date and place, and estigation, in my opinion, death occurred	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
)	Tot withi Tot comp	Ă	29b. Signature and title of certifie	29c. License number	29d. Date signed (Mopth, Day, Year)
	18		30. Name and address of person who o impleted cause of death (Item 23a) (Type, P	to Drive Chi	2/2(/2017 Lur, MUS 2/6/9
	Sta Registra	te ar	31. Date filed (Meath, Day, Year) 2007		

Brett Thomas			re All Cop nd Mental		_	2007	00080				
		1- For State Registrar		Cer	tificate of De	ath			eg. No.	L. W. J. J.	
Physicia Medical Exami		Decedent's Name (First, Middle, La Brett	st)	Th	omas			Date of Dea Month February		Year	3 Time of Death 1631 hrs
		4a. Facility Name (if not institution, gi Route 301 at Governor N				ty, Town, c	or Location of Dea	ath	4c. Co Cha	ounty of Death	
Funeral Director		5. Social Security Number 6. S 231–15–2056		e (In yrs. la	M	Jnder 1 Ye		Irs. 8. Date of Bir		Foreig	
	-	Usual Residence of Decedent	M 2 F		Yrs.		1 1			1 000	
nd show any	٦	MD State 10b. County St. Mar	ys		Town or Location anicsvill	e					10d. Inside City Limits 1 Yes 2 X No
e Maryla or 28a-f	Director	10e. Street and Number 27171 Oliver La	20		10f.	Zip Code 20659	<u> </u>	1	0g. Citizen	of What Coun	try?
with the ms 23a be noti		11. Marital Status	12. Was Decedent			edent of H		Specify Yes or No			can Indian, Black,
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	Never Married 2 Marrie Widowed 4 Divorce	1 X Yes 2	No		-	o specify:	to Rican, etc.)	Spe	White, etc. Whis	ite
2 hours a "natura Exami	ted b	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	only highest grade con College (1-4 or		16a. Decedent's Us during most of		ation (Give kind of e. DO NOT use n		16b. Kind	of Business/Ir	ndustry
0036 within 7 iene ner than Medical	Completed	12			Electri	cian	Lagazara	(E) 1 Middle		ontract	or
215-0036 be filed within 7 antal Hygiene rked other than rent, the Medica	a	17. Father's Name (First, Middle, Las Edmund	Κ.		Thoma		Angela	me (First, Middle, f	М.		Hammond
MD 21 Id 2 should alth and Me m 27 is ma aumatic ev	입	19a. Informant's Name/Relationship (Daphne K. Thomas			_			r Rural Route Nun R ichmond			Zip Code)
Ore, Notes I and of Health If item		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from Sta		Place of Disposition (rematory or other place)			Date 2/26.07	1	ation - City or	·
Baltimore, permit. Pages I ar Department of Hee Important: If ite	-	Donation 5 Other Specif 21. Signature of Faneral Soppler Dice			22 Name	and Addre	ss of Facility	Home P.A Annapo	i		
m	-	23a. Part I. Enter the disease, or com	plications that caused	the death.							Approximate Interval
/Medical Examiner			Multiple Injuries								Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as a conse	equence of	·):						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse								
		events resulting in death) Last	Due to (or as a conse	equence of):						
	edical	UNPENDED [AMENDED 23c. If yes, outcor	no of progr	22224				234 D	ate of delivery	
', P.O. Box 68760, ires that the death certificate be signed by the attending physicill be detached for use as the buri		23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	, -	2 Fetal de		Ectopic preg	nancy	Mo		ay Year
Box ne death the atte	골.	1 Yes 2 No 9 Unknow	n 9 Unknown		J Other (Lago Did to	20000 1150	contributo to t	he cause of death?
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On of vending Phath	tion: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju Feb 20, 2007	iry 'ear)	28b. Time of Injury 1125 hrs	28c. Inj	ury at Work? Yes 2 ✓ No	28d. Describe I Subject off I		occurred	
Division of Vital Records, tal or Attending Physician: The law requints after death all Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	2 Accident Investiga 3 Suicide 6 Could no determine	be 28e. Place of In		ome, farm, street, fac	tary, office	building, etc.	or Town, S	itate)		al Route Number, City Newburg, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur		29a. Certifier 1 Certifying Physic	cian: To the best of mer: On the basis of exa	y knowledg				nd due to the caus	e(s) and m	anner as state	đ
To the within To the comp	Medical	29b. Signature and title of certifier	and manner stated.				nse number	·		e signed (Mon	
-X		(al III)	Sompleted assess	loath /ltor	23a)	0.0	.M.E.		Februa	ary 23, 200	7
13,	ł		istant Medical Ex	kaminer	111 Penn St	reet, Ba	Itimore, MD 2	21201			
Sta Regist	nte rar	31 Date filed (Month, Day, Year) FEB 2 7	32. jegistra	r's Signatu	& Speed	U			_		
Registrat											

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** FEBRUARY 26, 9:47A 2007 MEARN L. THOMPSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES CLINTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV • 12, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days X1X M 2□F TEXÁS 81 1925 Director 448 18 8859 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1XXYes 2 □ No Director MD PRINCE GEORGES CAMP SPRINGS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20748 6307 BRINKLEY COURT Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. XIX Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 □ Yes XX No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT GOVERNMENT EMPLOYEE 1+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCES THOMPSON ADA M WOOTEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUCIE H. THOMPSON 6307 BRINKLEY COURT CAMP SPRINGS, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CEDAR HILL CEMETERY 03/03/2007 SUITLAND, MD ture of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Upper Castrointestinal
Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** -una Concer with metaslases Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as insequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown post radiation esophinaeal 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature And title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BONKS, MD Sandra CLINTON, MD 20735 7503 SURRATTS ROAD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 01 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State of Maryland		artment of Health		Hygien	211111	08082
		Decedent's Name (First, Middle, Last)			2. Date of		ay Year	3. Time of Death
Physic /Medi		Helen Thornes			Febr		25,2007	11:04aM
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	of Death	1	c. County of Death	
		Anne Arundel Medical Center	<u> </u>	Annapolis	er 24 Hrs. 8. Date of		rundel	Jane (Chata as Farring
Funeral Director		5. Social Security Number 5. 79 – 56 – 4461 6. Sex 1 M X F 6.3	st birthday) Yrs.	If Under 1 Year If Under Months Days Hours	Min. Feb	of Birth n, Day, Year 111,15	9. Birthe Cour	place (State or Foreign htry)
D.		Usual Residence of Decedent	T					Od. Inside City Limits
anylar show	_	,	Town or Lo					1 ☐ Yes 2 ☑No
Ba-f	ecto		ningt	10f. Zip Code		10a C	itizen of What Cour	
with t	ä	21 Atlantic Street SE		20032			JSA	,
eath	eral	11 Marital Status 12. Was Decedent Ever in U.S	i. 13.	Was Decedent of Hispanic C	Origin? (Specify Yes	or No-	14. Race - Americ	
after death with the Marylar after 48 or 1884 febow	by Funeral Director	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No		If Yes, specify Cuban, Mexico	an, Puerto Hican, etc	:.)	Black, White,	
ified within 72 hours after death with the Maryland Hygiene. Whysiene. Wher than "netural", or itams 23e or 28e-1 ehow ent, the Medical Evana entitlet at		3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specif	y:		Specify: B1	.ack
72 hours "natural",	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	16b.	Kind of Business/In	dustry
dithin dithin	ldu	Elementary/Secondary (0-12) College (1-4or 5+)		ountant		Der	t of Tr	Casury
lied w tygien her ti		1 2 17. Father's Name (First, Middle, Last)	ACCC		her's Name (First, M			casary
ie, Mal y Idalica ZIZIOOOO	Be	Wesley Solomon				Elder		
shoulk and Me mark mark	2	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Num				Code)
and 2 seath ar m 27 ie		Cynthia Johnson(Daughter)	1313	Belmont St	reet NW	Wash	,DC 200	09
is 1 and 2 if Health item 27 if other trees.		20a. Method of Disposition 20b. Pla	ace of Dispo metery, crea	osition (Name of matory or other place)	Date	20c. l	Location - City or To	own, State
Pages nent of h		1 Mariai 2 I Cremation 3 Hemoval from State		o Nat Cem	03/05/07	Tri	angle V	irginia
Datumore, to permit. Pages 1 an Department of Heali important: if item 2 eny injury or other once.		21. Signature Funeral Service Licensee		2. Name and Address of Fac yrone J. Yo		Kenn	edy St.	DC 2001 NW Wash
		23a. Part 1. Enter the disease, or complications had caused the death shock or leart failure. List only one cause or each line.	o not en	ter the mode of dying, such a	as cardiac or respirat	ory arrest,		Approximate Interval Between
Physician		Immediate Gause (Final disease or condition	nox	or coren	Lalana	Th,		Onset and Death
/Medical		resulting in death) Due to (or as a conseque	ence of):	1/	To John VI	+/		
Examiner	١.	Sequentially list conditions.	LIV	or tailur	1			
p tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):					
xecute and I-tran	xam	that initiated events resulting in death) Last Due to (or as a consequence)	ence of):					
of ou, sate be executed obysician and the burial-transit	calE							
ficate ficate physicate	edlo	U.						
death certifica attending ph	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal (⊒Ectopic pregnancy			23d. Date of deliv	
e death	Physician/Medl	in the past 12 nonths? 1 Yes 2/ No 9 Unknown 9 Unknown		Other (specify)			Month	Day Year
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aw rec	Completed				24a.	Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
VICAL DEC sicien: The law s certificate has b lirector, page 2 s	Eo				10	performed?	death?	2□ No
Physicien: This certificatral director, p	Be	25. Was case referred to medical examiner?			ce of Death (Check	only one)		
Physic this ce	ြိ	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Impatient 2 ☐ E	ER/Outpatie		Nursing Home 5		6 ☐Other (Special of the following occurred)	fy)
ing P	lo	1 Adatural 5 Pending (Month, Day Year)	28b. Time o Injury	of 28c. Injury at Work? M 1 ☐ Yes 2		, noe now m	diy occurred	
ittend death ctor: / the	ertification;	2 Accident investigation 3 Suicide 6 Could not be 28e, Place of Injury - At hor	me, farm, st		28f. Loca		and Number or Run	al Route Number,
affer affer d in by	erti	3 Suicide determined 28e. Place of Injury - At hor building, etc. (Specify))		City	or Town, Sta	ite)	
To the Hospitel or Attending Physicien: The I Within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know a complete the c	vledge, dear ion and/or ir	th occurred at the time, date nvestigation, in my opinion, d	and place, and due t eath occurred at the	time, date a	(s) and manner as s nd place, and due t	stated. o the cause(s)
o the vithin o the o the o the comple	Me	29b. Signature and title of certifier		29c. License numbe	r	29d. C	ate signed (Mohth,	Day, Year)
11		> 12 William mp		1)3844	15	0.	2/26/2	60-7
Coip		30 Name and address of person who completed cause of death (Item	23a) (Type	Print) Modical	Parkusa	An	we An	1401/ Md
SI	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signate	ure	MRUILAL	MANUFY	110	74/6	in a part
Regis		MAR 01 2007 Back D. See	AL S					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar TCHD, 02/27/07, sbb Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 10 2007 domani Ronald C. Turner, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Jemana (Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-05-1945 If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Min 1 M 2 □ F Months Days Hours 61 Maryland Director Usual Residence of Decedent 10d. fnside City Limits 10c City Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatih and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow eny Injury or other traumatic event, the Medical Exacting trust be rediffed at 1 Yes 2 No Director Maryland Talbot Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 USA 26981 Tunis Mills Road Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Turner's Heating 15. Decedent's Education (Specify only highest grade completed) Air Conditions Elementary/Secondary (0-12) College (1-4or 5+) Owner -Operator 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Jackson Harriet 0tis Turner Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O.Box 1414, Easton, Maryland 21601 Ernestine Turner / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Richards Memorial Cem 02-17-2007 Easton, Maryland 22. Name and Address of Facility
Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee nme 426 Dover Street, Easton, Maryland 21601 Part 1. Enter the disease, or unplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Soms ON /Medical Due to (or as a consequence of): Examiner 11710 Sequentiarly its conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit ettending physicien and Due o (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ğ 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Pes 2 □ No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: ٥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident efter death Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Soull 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Ludwig J. Æglseder/, III 503 Cynwood Ave Easton, MD 21601

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 4 2007

32. Registrar's Signature

		1 _ For State	State of M		nd / De	partment of	Health and			
	-	Registrar 1. Decedent's Name (First, Middle	o Last)			ertificate of	Deam	O Data of D	Reg. No.	<u>07 08084</u>
Physicia /Medic		Thomas	A			Turner		2. Date of De Month Februa	Day	Year 2007 11:00 PN
Examin		4a. Facility Name (If not institution	n, give street and number,)			or Location of Deat		4c. County	
		Civista Med:		r		LaPlat			Char	les
Funeral		5. Social Security Number	6. Sex 7. A		last birthda	Months Days			rth ay, Year)	Birthplace (State or Foreign Country)
Director		213-40-5271 Usual Residence of Decedent		70	Yrs.					Maryland
land ow		10a. State 10b. County		10c. Cit	y, Town or	Location				10d. Inside City Limits
Mary fied a	tor	Maryland Cha	rles		LaP]	ata				1 XYes 2 □ No
h the	Director	10e. Street and Number	1105			10f. Zip Code			10g. Citizen of	What Country?
th wit		101 Wesley D	rive Apt.#	1222		20646			USA	
r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	.S. 1	3. Was Decedent of If Yes, specify Cut	Hispanic Origin? (S	Specify Yes or No		ce - American Indian, ck, White, etc.
s afte	by Fu	1 Never Married 2 Married	If Yes, Give	No		1 ☐ Yes 2 X No				v. Black
hour tural'	q pe	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		16a Day	cedent's Usual Occu				
filed within 72 hours after death with the Maryland Hygiene, Hygiene, what watural", or Items 23a or 28a-f show wht, the Medical Examiner must be notified at	Completed		st grade completed)		(Gi	ve kind of work done . DO NOT use retire	pation during most of wo ed)	rking	160. Kind of B	usiness/Industry
d with giene r tha	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	1	iver	•		Miller	Lumber
e filec at Hyg othe vent,	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	me (First, Middle		
wild b Menta	10	Clarence	A		Turn	er	Irene			Wright
2 sho and is ma		19a. Informant's Name/Relations	hip (Type. Print)		19b. Ma	iling Address (Stree		ural Route Numb	er, City or Town,	
and lealth m 27 her tr		Jean Turner	/ Wife	T	101	Wesley I	Dr.Apt 2			aryland20646
ges 1 t of H if ite or ot		20a. Method of Disposition 1 Mail Burial 2 ☐ Cremation	3 ☐Removal from State		Place of Dis cemetery, c	position (Name of rematory or other pla	ice)	Date	20c. Location -	City or Town, State
tmen tant: tant:		4 ☐ Donation 5 ☐ Other (S	pecify)		. Ma	rys	03/0	2/2007	Bryant	own, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	licensee	ic i		22. Name and Addr	ess of Facility Ac	lams Fu	neral	Home PA
22200		23a Part Enter the disease of	and and in a that any and	<i>[5]</i>	K	UDUS AQU	iasco Ro	i.Aguas	co. Ma:	ryland 20608
E-day.		23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final					ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)			Ni	4				11445
Examiner			Due to (or as	a consequ	uence of):					WEEKS
	Jer	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	b. Due to (or as	-	uence of):					WEEKS
be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c							
be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):					
eath certificate be ey attending physician for use as the buria	ical		d	**						
ing pleas t	Physician/Medic	IF FEMALE:	T							
ath co	au/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Feta	Ideath 3	□Ectopic pregnanc	у			te of delivery nth Day Year
the a	vsic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of d	eath 5	Other (specify)			IVIO	nth Day Year
that the de ned by the a detached t	P.	Part II. Other significant condition	ns contributing to death b	out not resu	utting in the	underlying cause giv	ven in Part I	23e Did to	ohacco use cont	ribute to the cause of death?
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w requir been si should I	ete						-	04. 141		
he lav e has ige 2	Completed							24a. Was autor perfo	osy r	Were autopsy findings available prior to completion of cause of death?
sician: The certificate herector, page		25. Was case referred to medical						1□ Yes	2 No 1	I∐Yes 2 No
ysicla s cert	To Be	examiner?	Hospital:	ant 2 🗆	ER/Outpatio	ent 3 DQA Oth	or:	ath (Check only o		(2 (1)
g Physicar this leral direction		27. Manner of Death	28a. Date of Inju	ıry	28b. Time	of 28c. Inju	rv at	lome 5 Resid	now injury occurr	
ath. or: After ne funer.	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	ation (Month, Da	y rear)	Injury		rk? Yes 2∐No			
er de irecto	Certification:	3 ☐ Sulcide 6 ☐ Could n 4 ☐ Homicide determi		ury - At ho	me, farm, s	street, factory, office		28f. Location (S City or Tox	Street and Numb	er or Rural Route Number,
ital o rrs aft ral Di led in	Ce								,	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best Examiner: On the basis o and manner sta	f examinat	wledge, dea tion and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)
To the within To the comple	Ğ	29b. Signature and title of certifier			1 -	29c. Licens	se number		29d. Date signed	i (Month, Day, Year)
		> Muchael	Vemale	R-1 K	10	H- 0	042445		Februa.	23 2007
200		30. Name and address of person				, Print)				ry 23,2007
105		Michael A. Pi	mentel 601	Pos	st Of	fice Rd	Suite	1-A Wal	ldorf,	MD 20602
Stat Registra	e Ir	31. Date filed (Month, Pay, Year)	8 2007 32. Registra	ars Signal	ure K	Somet,				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Month Year **Physician** 22 2007 February 8:10P Molly Veney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing Home Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 F Yrs. Director May 12, 1924 North Carolina 578-64-5732 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County i Hygiene. other than "natural", or Items 23e or 28e-f ehow vent, the Medical Examinar must be notified at 1 XYes 2 No Director Landover Maryland | Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20784 6810 Randolph St. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Maritaf Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Yes, Give Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12th Aide/Teacher Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Is marked eny linjury or other traumatic evens. Martha Emma McCoy Grant Penny 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7508 Taylor St., Hyattsville, MD Brenda Brown/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 3/2/2007 Cheltenham, MD 22. Name and Address of Facility 21. Signatule of Funeral Service Licensee Stewart Funeral Home Wash., DC 20019 4001 Benning Rd., NE war Mu 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cayse given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performe 1 Yes 2 No 1 Yes 2 No After.
.er death.
Jirector: After this ceru...
.the funeral director, p? Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dec. 5 Pending 1 TYes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide To the Hospital of within 24 hours af To the Funerel D completely filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 20912 7701 Carroll Ave., Takoma Park, MD Nasreen Kango, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

		Plea	ase Type or I							egible.	
		For State	State of	Marylai			Health and I	Mental Hy	giene	007	0000
		Registrar	H= l=at)		Ce	rtificate of	Death	O Data of D	Reg. No.	UU/	<u> </u>
Physicia	n	1. Decedent's Name (First, Midd	ile, Last)					2. Date of De Month	Day	Year	
/Medica	ıl	John T. Wade				1 0:: =		Febru		22 200	
Examine	r	4a. Facility Name (If not institution					or Location of Death	1		ounty of Dea	
粉		South River 5. Social Security Number		Rehab 7. Age (In yrs		Edgew If Under 1 Year		8. Date of Bi		le Arı	
Funeral Director		216-44-7322	1√E M 2□ F	7. Age (III yis	59 Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	_ C	thplace (State or Forei ountry)
ATAL SAN		Usual Residence of Decedent			59			Mar 8	194	/ Mai	ryland
ylanc now at		10a. State 10b. County	/	10c. C	ity, Town or L	ocation					10d. Inside City Limit
Mar a-f st	io	Maryland Anne	Arunde1	An	napo1	is					1 DXYes 2 □ N
or 28	Directo	10e. Street and Number				10f. Zip Code			10g. Citize	en of What C	ountry?
h with	<u> </u>	410 Oaklawn	Ave			214	01		Ţ	JSA	
deat	runeral	11. Marital Status	12. Was Dece Armed For		J.S. 13.	Was Decedent of I	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No	0- 14		erican Indian,
or ite		1X Never Married 2 ☐ Mar	rried 1 ☐ Yes If Yes, Giv	2 X) No		1 ☐ Yes 2 ☐XNo		o riidan, etc./		Black, Whi	_{te, etc.} Black
ours Iral", Exa	o l	3 ☐ Widowed 4 ☐ Divorce	d Year or Da	ites:		1 Les 2 Lagro	ореспу.		5	Specify: J	Diack
72 h "natu dlca	ala	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece	edent's Usual Occu e kind of work done	pation during most of wor ed)	king	16b. Kind	d of Business	/Industry
vithin the. than	Comprehen	Elementary/Secondary (0-12)	College (1-	-4or 5+)			ed)				
Hygie Ther I		12th 17. Father's Name (First, Middle	() () () () () () () () () ()			aborer	18. Mother's Nan	oo (Eiret Middle		Emp.	Loyea
or the standard or the standar	0	John Wade	, 2037				Raphae1		_	urranie)	
hould Me mark mark	2	19a. Informant's Name/Relations	ship (Type Print)		19h Mail	ing Address (Street	and Number or Ru			Faura Ctata	Zin Code)
d 2 s th an th an trau		Agnes Simms(_		
1 an Heal Gem 2		20a. Method of Disposition	sister)	20 b		Oaklawn osition (Name of or ather pla		nnapol Date		ation - City or	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 4 Donation 5 Other (emoria	al Park	3-2-		Anna	apoli	s, Md.
permit. Departn Importa any inju once.		21. Signature of Funeral Service	Licensee				^{జ్ర} ీక్ ^{acil} Sons				
_ = a o		Lavry S.	Reese MS				St. Anı	AL .		1. 214	101
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/Medical Examiner		resulting in death)	('0	or as a consec		11	173.				
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that the ed by detac		Part II. Other significant conditi	ions contributing to de	ath but not res	sulting in the L	inderlying cause aix	ven in Part I.	23e. Did	tobacco use	e contribute to	o the cause of death?
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Ö Be

Certification: To

Medical

25. Was case referred to medical examiner? 1 ☐ Yes Q No

27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

29a. Certifier (Check only one)

29b. Signature

6 Could not be determined

5 ☐ Pending investigation

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29c. License number

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29d. Date signed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

ROUGH HO

Day, Year)

32 Aegistra's Signature

31. Date filed (Month, Day, Year)
FEB 2 7 2007 State Registrar

07-01551 Juan Walker

uan vvaiker		- For State	St	ate of Maryla		epartm C <i>ertific</i>			d Menta	al Hyg		Reg. No.	200	Mental Street	08087
Physician Medical Examine	"	I. Decedent's Name									Date of Dea	ath Day	Year	3.	Time of Death 0233 hrs
predical Examine		Juan Av 4a. Facility Name (if		n, give street and nu	mber)		4	b. City, Town, or	Location of		February		O7 County of D	eath	0233 Hrs
		7018 Hanove						Greenbelt					rince Ge		
Funeral Director		5. Social Security Nu		6. Sex	7. Age (In	yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	_	24Hrs. 8 Min.	B. Date of B	irth(MM/E	1969	Birthporeign Count	Washingto:
any	_	Usual Residence of I	Decedent Ob County		10c	. City, Town	or Location	on .						110	Od. Inside City Limits
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er death w		11. Marital Status 1 X Never Married 3 Widowed		12. Was Dec Armed Fo 1 Yes orced If Yes, Give Yea	orces?		If Ye	B Decedent of Hispes, specify Cuban,	Mexican, F	n? (Speci Puerto Ric	fy Yes or N	0-	14. Race - A White, e	mericar tc.	n Indian, Black,
ours after trural" samine				or Dates: cify only highest grad			Decedent	's Usual Occupati	on (Give ki	nd of work	k done		Specify: B ind of Busin	<u>lac</u> ess/Indi	
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5-0036 Iled within 72 hour Hygiene. Johner than "natu the Medical Exan	<u> </u>	12 17. Father's Name (F	iret Middle	Last)			Logi	istics S	oecia.	list	irst, Middle,	Maidan	Priva	te	
21215-0036 Mental Hygiene, marked other than e event, the Medica		Bobby		,							Wau1				
> 21 hould bend Mer is mar tife eve	15. Decedent's Education (Specify only highest grade completed) 16. To Dates: 17. To Dates: 18. Decedent's Education (Specify only highest grade completed) 19. Decedent's Education (Specify only highest grade completed) 10. Decedent's Education (Specify only highest grade completed) 10. Decedent's Education (Specify only highest grade completed) 11. Father's Name (First, Middle, Last) 12. Decedent's Name (First, Middle, Last) 13. Bobby Walker 14. Decedent's Name (First, Middle, Last) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) 18. Decedent's Name (First, Middle, Last) 19. Decedent's Name (First, Middle, Last) 19. Decedent's Name (First, Middle, Last) 19. Decedent's Name (First, Middle, Last) 20. Decedent's Name (First, Middle, Last)						b. Mailing	Address (Street						State, Z	ip Code)
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iore ges 1 g t of H _d		1 X Burial 2	Cremation	3 Removal fr	om State	cremat	ory or oth	er place)						•	
Baltimore, Pepers I and Department of Healt Important: If iteal injury or other training or other trai		4 Donation 5 21. Signature of Fun			-	Harmon	ny Me	emorial I	of Facility	3/10	0/07	Lan	dover	, MI)
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Physician //Medical	1	23a/Parl I. Enter the failure. List only	disease, or one cause	complications that c	aused the	death. Do n	ot enter th	e mode of dying,	such as car	rdiac or re	spiratory ar	rest, sho	ck, or heart		Approximate Interval Between Onset and
Examiner		Immediate Cause (For condition resulting		a. Contac		hot wou	ınd to	head						1	Death
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Division of Vital Records, P.O. Box 68760, note Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The right of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Contribution I Do Completed by Divisional Madical Experience.	2	F FEMALE: 3b. Was decedent p past 12 months?	,	ne 23c. If yes,	outcome of	f pregnancy	2 Fet	al death 3 [ner (Specify)		pregnancy	у	- 1	. Date of de Month	livery Day	Yea r
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Division of Vital Records, P.O. B at or Attending Physician: The law requires that the d at Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached this control of the Division of Day of the Division of Day of the Day	ŝ	Part II. Other signifi	icant condit	ions contributing to	death but	t not resultin	g in the u	nderlying cause g	iven in Parl	t I.			No 3		e cause of death?
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Vital Reconstitute of the continue of the cont		examiner?	No No	Hospital:	Inpatient	2 ER/C	utpatient		of Death (C		dome 5	Resider	nce 6 🗸	Other: S	cene
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Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: Aft completely filled in by the fune		3 X Suicide 4 Homicide	6 Cou	d not be 28e. Plac	e of Injury house	- At home, f		t, factory, office b	uilding, etc.	28 G	or Town, reenbe	(Street ar State) / Lt, MD	018 Har O18 Har	or Rural 10Ver	Route Number, City Pkwy D2
To the Hos within 24 h completely	ē			hysician: To the beaminer: On the basis and manners	of examina										ause(s)
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R		30. Name and addre		who completed cau			er 11	1 Penn Street	. Baltimo	ore. MD	21201				
Stat	te.	31. Date filed (Month				ignature		3.1001	.,						
Registra	ar	M A D ()	8 200	1 Mary	. 1.	Dod	A Park								

		-	For State Registrar	State of Maryla		artment of H rtificate of I			jiene _{leg. N} o?	7 08083
**		- In	Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	th Day Ye	3. Time of Death
	Physicia /Medic		Donald Lloyd White	2, Sr.				Februa	ry 27, 20	007 2:30 PM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of D	
Will be			47 Cherry Street				ing Sun	La But (Bit)		Cecil
***	Funeral		5. Social Security Number 6. So	ex 7. Age (In)	rs. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year) 9.	Birthplace (State or Foreign Country)
E)E-A	Director		216-20-1043 Usual Residence of Decedent	7	9			Augusi	20, 1927	Maryland
	/land low at		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	a-f sh ified	cto	Maryland Ceci	l	Risir	ig Sun				1X Yes 2 No
	th the or 28 e not	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	t Country?
	ath w	rall	47 Cherry Street				21911		USA	American Indian,
	er dea items	Funeral	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecity Yes of No- Rican, etc.)	Black, V	Vhite, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced	1 ∐ Yes 2 💢 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛱 No	Specify:		Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	
215	hin 73 9. an "n Medl	ple	(Specify only highest gra	de completed) College (1-4or 5+)		kind of work done DO NOT use retired	during most of work d)	ang		
21	er the	Completed	11		Mech	ranic			Automot	ive
nd	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
Ŋa	ould I Men sarke	은	Marion Thomas Whi		40h Maili	Add-oos (Ctroot		La Mae To	erry er, City or Town, Sta	to Zin Cada)
Maryland	12sh hand 7Ism traum		19a. Informant's Name/Relationship (*) Ruth White/Daught						MD 21911	ie, zip code)
6,	1 and Healt em 2		20a. Method of Disposition		b. Place of Dispo	sition (Name of		Date Juni,	20c. Location - City	y or Town, State
nor	ages ant of t: If It y or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification Specification Specifi	Removal from State		matory or other plac w Cemeter		-2007	Risina	Sun, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer			2. Name and Addre	3			San, morey-corre
ä	permi Depar Impor any Ir		Wichard d	loodi.	8. 111 S.	Queen.	St. Risi	ng Sun MD 21911		
焦	# .780		23a. Part1. Enter the disease, or com shock or heart failure. List only	plication, that caused the cone car e on each line.	death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Metast	afic	Kecta	1 Ca	Vanon	ua	Onset and Death
d	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
Ē.	LAdimine	_	Sequentially list conditions,	b. — Due to for as a con	nazwonec of					
	ted nsit	nine	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Let	Dus to (01 as a sc)	ooquonoo oij.					
3	execunate and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	sequence of):					
8760,	icate be executed physician and s the burial-transit	dical	•	_d						
9	rtifical ng ph as th	a l	E ECMAL C.							
Box	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pro 1 ☐ Live birth 2 ☐	Fetal death 3	⊒Ectopic pregnanc	y		23d. Date of Month	
E	e dea the at ned fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5[Other (specify)				
<u>α</u>	The law requires that the death certifi tte has been signed by the attending vage 2 should be detached for use as		Part II. Other significant conditions	contributing to death but not	t resulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
or Vital Records,	w requires that been signed to should be det	d by						1 🗆 1	Yes 2 No 3[☐ Probably 4 ☐ Unknown
Sor	w requ been shoul	Completed						24a. Was	an 24b. Wei	re autopsy findings available
Re	The larate has	щ					· · · · · · · · · · · · · · · · · · ·	autop	osy prio rmed? dea	r to completion of cause of
ta		a)	25. Was case referred to medical				26. Place of Dea			res 2 140
<u>></u>	Physician: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 ∑ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3□ DOA Oth	ner: 4 \(\text{Nursing H} \)	ome 5 🕅 Resid	dence 6 Other	(Specify)
0 1	ng Ph tter th neral	n: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time (of 28c. Inju Wo	ry at rk?	28d. Describe h	now injury occurred	
Sio	Attending r death. ector: After by the fune	ätic	2 ☐ Accident investigation				Yes 2 □ No			
Division	or Att after da Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		At home, farm, st pecify)	reet, factory, office		City or Tox		or Rural Route Number,
	pital ours a eral [29a. Certifier 1 X Certifying Pl	nysician: To the best of my	/ knowledge, dea	th occurred at the ti	ime, date and place	e, and due to the	cause(s) and mann	er as stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Medical	(Check only 2 Medical Examone)	miner: On the basis of exa and manner stated.	mination and/or i	nvestigation, in my	opinion, death occu	irred at the time,	date and place, and	d due to the cause(s)
_	To th within To th comp	ĭ.	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (I	/
			And	MD		126	0768		2/28/	2007
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)	0,	2000	1011	
	3		, , ,	28/ E. Mai	n Sty /	Print)	oun, 1	(11) 2	1741	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's 9	agriature .	merce				
	riegist		_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otato of it	nai y iai ic		tificate o			nemai riy	Reg. No	/ 1111/	080	189
	Physici	an	1. Decedent's Name (First, Middle, L							2. Date of Dea	ath Da	y Year	3. Time of	Death
	/Medic		Pauline Iren							Februar		4, 2007	3:25	Рм
j	Examin	er	4a. Facility Name (If not institution, g 2729 Sprague Dr		er)		4b. City, Town	, or Location aldorf			40	Charles	:	
	Funeral Director		5. Social Security Number 6.		Age (In yrs. Ia	st birthday). Yrs.	If Under 1 Year Months Day	r If Under		8. Date of Birt (Month, Day July 25	th y, Year	9 Rinth	place (State o	r Foreign
	p		Usual Residence of Decedent			Town or Lo	antion			pu.y =0	,		<u> </u>	
	larylar show	'n	10a. State 10b. County Maryland Char	1.00	,	Valdor							10d. Inside Cit 1 ☐ Yes	
	the M 28a-f notifie	rect	Maryland Char 10e. Street and Number	162	V	valuor	10f. Zip Code	,		1	10g. Ci	itizen of What Cou	ntry?	
	h with 23a or st be	al Di	2729 Sprague Dri	ve			20	601				U.S.A.		
	tems tems	Funeral Directo	11. Marital Status	12. Was Deceder Armed Force	s?	i. 13. V	Was Decedent of f Yes, specify C	f Hispanic Or uban, Mexica	rigin? (Sp	ecify Yes or No- Rican, etc.)	n .	14. Race - Ameri Black, White,		
036	urs afte al', or i	by	1 ☐ Never Married 2 ☐ Married 3 🔣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ∑ If Yes, Give Year or Dates		1	I□Yes 2KLIN	o Specify	•			Specify: Wh	te	
5-0036	72 hor	eted	15. Decedent's (Specify only highest g	Education rade completed)	1	16a. Deced	lent's Usual Occ kind of work dor DO NOT use reti	upation e during mos	st of work	ting	16b. K	(ind of Business/Ir	dustry	
2121	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		naker				_	ome Owner	•	
Maryland	eve d	To Be (17. Father's Name (First, Middle, Las Floyd Earnest	st)						e (First, Middle, Osborne		n Surname)		
/ar⟩	2 a a	ľ	19a. Informant's Name/Relationship								-	or Town, State, Zi	•	
	1 and Health tem 27		Richard Wayman/S	on	20b. Pla	39/9 ace of Dispo	Iranqui sition (Name of natory or other p	lity L		King G		ge, Virgi ocation - City or T		485
ē	m O	i	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from Sta	le		matory or other p ematory		2-27-	2007	Wal.	dorf, Ma	rvland	
Baltimore,	permit. Page Department Important; If any injury or once.		21. Signature of Funeral Service Lic	ensee M01391		22	. Name and Add	Iress of Facil	ity	3035 0	1d W	Vashingto	n Road	
Ш	20 E 20		23a. Part1. Enter the disease, or co	- linetions that save	and the death							Maryland		
	Physician ¹		shock, or heart failure. List on Immediate Cause (Final	y one wuse on each	line.								Approximate Interval Bet Onset and D	ween Death
	/Medical		disease or condition resulting in death)	Due to (or a	as a conseque	ence of):		050		U II	· / ,	7	x yes	1500 150
H	Examiner	L	Sequentially list conditions,	b. CHYP			ENI	+1.	FA	TW	rur:	_, ×	Mon	21 PS
	rted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a conseque	0.6%	1 ART	KIR	7 m	Jusie	ne) ,	c of	(Land
o,	execu an and rial-tra		that initiated events resulting in death) Last	C	as a conseque		113.0		1				-	
68760	icate be executed physician and s the burial-transit	Medical		d		_	J)					-
Box 6	certific nding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23d. Date of deliv	erv	
о. В	The law requires that the death certificate be executed te has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 □ Fetal at time of de]Ectopic pregna] Other (specify)					Month		/ear
_	w requires that the d been signed by the should be detached		Part II. Other significant conditions	contributing to death	n but not resul	ting in the ur	nderlying cause	given in Part	i.	23e. Did to	obacco	use contribute to t	he cause of d	eath?
ecords,	equires en sign	ed by								1 🗆 ነ	Yes 2	2 No 3 □ Pro	bably 4 □L	Jnknown
	law re las bee	Completed								24a. Was	an osy	24b. Were autoprior to co	opsy findings a	available ause of
E E										perfò 1∐ Yes	rmed? 2 X No	l death?	2 □ No	
Vital	Physiclan: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	atient 2□E	R/Outnatien	t 3 DOA)thar:		h (Check only o		6 ☐Other (Speci	£.)	
סר	ding Phys h. After this funeral dir		27. Manner of Death	28a. Date of I		28b. Time of Injury			ursing ric	28d. Describe h			(9)	
SIO	tendir eath. tor: Af the fur	catio	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	on			M 1	☐Yes 2☐]No					
Division	cal or Attend s after death al Director: / ad in by the f	Certification:	4 Homicide determine	a Zoe. Place of	injury - At hon etc. (Specify)	ne, farm, str	eet, factory, offic	e		28f. Location (S City or Tox		nd Number or Rur le)	al Route Num	ber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier (Check only one) 1 ertifying l	Physician: To the be aminer: On the basis and manner	s of examinati	/ledge, death on and/or in	n occurred at the vestigation, in m	time, date a y opinion, de	nd place	and due to the rred at the time,	cause(s date ar	s) and manner as and place, and due	stated. o the cause(s	;)
	To the within To the complete	Me	29b. Signature and title of certifier		1	m	29c. Lice	nse number	1	24	29d. Da	ate signed (Month,	Day, Year)	
1			30. Name and odress of ers in wh	o completed callse o	f death (Item	23a) (Type,	Print)\	N	6	100	0	X 126	101	MD
_	B7 Sta	ite_	31. Date filed (Month, Day, Year)	- A7	Strar's Signati		w,1,	170,	· W	JAW	STO	XVVLO	206	505
	Registr	ar	FEB 2 8	2007	eur s	K A	ment							
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		For State	State of Maryland / Department of Health and Mental H Certificate of Death								-0000 00000			
	C A	Registrar 1. Decedent's Name (First, Middle, La	st)		Cert	ilicate of	Dealli	2. Date of Dea	Reg. No.		3. Time of Death			
Physici		Gregory Alexander	,					LEDNIO	Day	Year	2034 M			
/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town,	or Location of Deat	, , ,	4c. County	of Death				
		MenorialA	aspita			ERS	ton		16	7/6	of			
Funeral Director			Sex 7. Age	e (In yrs. last i	birthday) _ 1 Yrs.	Months Days		8. Date of Birt (Month Date 09-07-]	, Year) . 955	Coui	place (State or Foreign ntry) ton, MD			
show d at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, To		ation				1	10d. Inside City Limits			
Ba-f s	ecto	MD Talbot		Cordo	va	1					1 Yes 2 No			
th with the 23a or 2 ast be no	al Dir	10e. Street and Number 10499 Chapel Rd.				10f. Zip Code 21625			10g. Citizen of JSA	What Coul	ntry?			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 □ Never Married 2 ★ Married	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give			_	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	0 %					
ural",	d by	3 Widowed 4 Divorced	Year or Dates:			□Yes 2万No				Specify: Black				
"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	6a. Decede (Give k	ent's Usual Occu ind of work done O NOT use retir	upation e during most of wo ed)	rking	16b. Kind of B	usiness/In	dustry			
withir iene. than the Ma	шо	Elementary/Secondary (0-12)	College (1-4or 5			Driver	cu)		R. L.EV	IING				
e filed Il Hyg other ent, t	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,						
uld be Venta Irked Itlc ev	To B	Wilmer Magee			Frances Webb									
2 sho and l is ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Warner Webb / Wife 10499 Chapel Rd. Cordova, MD 21625												
1 and Health em 27 ther to		Veronica Warner Wo	ebb / Wife			Chape1 ition (Name of	Rd. Cordo	ova, MD 2	1625 20c. Location	City or To	own State			
ages int of h		1 ☑ Bunal 2 ☐ Cremation 3 ☐		ceme	etery, crem	atory or other pl	etery 2/2		Presto					
artme ortani injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		110.			ress of Facility B			-				
permi Depar Impor any ir once.		Jammie	11 Sh	31.1)	42	6 Dover	St. East	on MD 2	1601					
"		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	I the death. D	o not ente	r the mode of dy	ving, such as cardia	c or respiratory ar	rest,		Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition	a Ant	win	acle	satio	Hee	et De	sles	2	Onset and Death			
/Medical Examiner		resulting in death) Due to (or as a consequence of):												
	<u>_</u>	Sequentially list conditions, if any, leading to immediate												
uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as	21-1	1-6	110	Ut f	1.0.20	7					
icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	consequence	ce of):	- MC	4 1	ann a	-					
tte be iysicia ne bur	ical	•	d											
ertifica ing ph e as th	Med	IF FEMALE:												
eath certific attending pl for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal dea	ath 3 □	Ectopic pregnan Other (specify)	су			ate of deliv onth	ery Day Year			
uires that the de n signed by the a Id be detached f	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown											
ss that gned to be det	by P	Part II. Other significant conditions	contributing to death be	ut not resulting	g in the und	derlying cause g	iven in Part I.	23e. Did to	obacco use con	tribute to t	he cause of death?			
w require been signal								1 🗆 \	res 2 No	3 Prol	bably 4 Unknown			
Physician: The law requires that the death certificate be this certificate has been signed by the attending physicis rail director, page 2 should be detached for use as the but	Completed							24a. Was autop perfo 1□ Yes		prior to co death?	opsy findings available impletion of cause of			
lan: ertifica stor, p	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o						
hysic this ce al direc	To E	1 ☐ Yes 2 No	Hospital: 1 Inpatie		Outpatient	3 DOA		Home 5 ☐ Resid	dence 6 □Ot	her (Speci	fy)			
iding Physician: h. After this certifica		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Day		b. Time of Injury	28c. Inj W		28d. Describe h	now injury occu	rred				
death ctor: ,	icati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number)								al Boute Number				
after after Direct	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	,, 600	,, onlot	-	City or Tov		_o, or run				
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C		hysician: To the best miner: On the basis o and manner sta	f examination										
12 T 5	177													

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAHBUSA AUHTER, 607

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 2 2 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 4:10 PM M March 9, 2007 Mirza Qamar Ahmad /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1**X** M 2□ F Yrs 60 March 31, 1946 Director 563-02-0325 India Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9107 Charred Oak Drive 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American India 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Asian Indian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ranjury or other traumatic event, the Medones. Elementary/Secondary (0-12) College (1-4or 5+) 5+ World Bank Financial Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mirza Zafar Ahmad Nasira Ahmad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jean P. Ahmad/ Wife 9107 Charred Oak Drive Bethesda, Maryland 20817 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemeter, crematory or other place)
Montgomery
Crematorium Inc. 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State March atorium Inc. 13, 2007 Bethesda, Maryland

22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M0033523a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Atherosclertic Heart Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1∐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 2 X ER/Outpatient 3 DOA 1 Tes 1 Inpatient ٩ this funerai 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

| HMAD | MIRIA 3-9-61 T.O.D. | IL Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

Hospital or Attending 44 hours after death. hin 24 hours after death the Funeral Director: completely filled in by To the within ?

State Registrar

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road Bethesda, Maryland 20814 Mauish Oza, M.D.

31. Date filed (Month, Day, Year) MAR 1 5 2007

4 Homicide

29a. Certifier

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0057011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Joan Merryman March 2007 Buchan 3:27 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 220-14-0367 84 Director DEC 15. 1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic event. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2√□No MD Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Dunvale Road. 21204 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: White ģ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Merryman Lily M. Dixon ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Buchan/Son 450 Morgan Ford Rd Front Royal, VA 22630 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 3/14/07 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MI Could Frederick Rd Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listerily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 22 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical Certification: To 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of pers no completed cause of death (Item 23a) (Type, Print) auto-Street 1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2007 10:30 A M March Mary Irene Brettschneider /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Ellicott City 3020 N. Ridge Rd W-126 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 TF 89 May 7, Maryland Director 212-09-4097 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Ellicott City MDHoward 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1 21043 USA 3020 N. Ridge Rd, W-126 Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 X No Specify: White 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced er than "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Proof Reader Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic ever Clarence Kyle |Mary Hardy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a William H. Brettschneider/husband 3020 N. Ridge Rd, W-126 Ellicott City, MD 21043 If Item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Department o Important: If any injury or once. Metro Crematory, Inc 3/14/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring Approximate interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only are cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed after death. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 2☑ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

within 24 hours after death. **Ço the Funeral Director:** After the completely filled in by the funeral. To the Hospital o within 24 hours aft To the Funeral DI

> State Registrar

29b. Signature and itle of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Hending

29c. License number

Geipe Rd, Catousville

29d. Date signed (Month. Dav. Year)

and manner stated

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

08094

		•	For Amend #10c, p	erFH, g865, 3/	15/07	TI Depa Cei	artmen <i>tificati</i>	t of Health e of Deal	n and M <i>th</i>	ientai Hy	/giene Reg. No.	. 0 0 7	000074
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	/Medic Examin		4a. Facility Name (If not institution	give street and number,		*	1	Town, or Location	on of Death			County of Death	1
	- Funeval:	~	2609 Oncpe 5. Social Security Number	6. Sex 7. Ac		406 ast birthday)	ff Under	Mbnlls 1 Year If Und	der 24 Hrs.	8. Date of B	-th	me Am 9. Birth	place (State or Foreign
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	dea dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13. \	Was Deced	dent of Hispanic city Cuban, Mex	Origin? (Specican, Puerto	ecify Yes or N Rican, etc.)	0- 1	4. Race - Ameri Black, White	
036	within 72 hours after ane. then "natural", or ite	by	1 ☐ Never Married 2X Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		53	1 🗆 Yes	2€ No Spec	city:			Specify: Whi	te
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aryl	2 should be it and Mental h ie marked ot raumatic ever	<u>م</u>	Clyde L. Bell,			19b. Mailir	ng Address					Town, State, Zi	p Code)
	1 and 2 Health 3 Inn 27 i		Betty A. Bell / 20a. Method of Disposition	spouse	20h P	2604 lace of Dispo		el Lake	_	#406		cills, M	1D. 21054
mor	Pages ent of I nt: if ite ry or of		1 ☐ Burial 2 📉 Cremation 4 ☐ Donation 5 ☐ Other (S)		, ce	emetery, crer	natory or o	other place)	1			exandria	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 ie marked any injury or other traumatic e <u>once</u> .	Ì	22. Name and Address of Facility Beall Ft 6512 NW Crain Hwy. Bowl									l Home	
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	. \		• /	- Rhee M	(1)			1)006	,437	9	3	14/07	
5	X		30. Name and address of person	who completed cause of	death (Item	123a) (Type, 1857-52t	Print)	DODG	300	Annap	olus 1	ND 214	401
34	Sta Regist		31. Date filed (Month, Day, Year)	2007 32 legis	trar's Signa	ture	alle			1			

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			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	lilicate of t	Dealli	2. Date of De	Reg. No.		3. Time of	(Death	
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	/Medic		4a. Facility Name (If not institution, give s		Dassaru	4b. City. Town. o	r Location of Death	march	4c. C	ounty of Death	1-10		
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	Funeral				(In yrs. last birthday)	If Under 1 Year		8. Date of Bir (Month, Da		9. Birthp	place (State of	or Foreign	
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36	rs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		s	pecify: Wh	ite		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	be	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind	of Business/In	dustry		
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21	ed with	mo.	10	Conego (1 40) O	Labo	rer			Stru	cture			
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<u>la</u>	Ment Ment	To	Clarence Bussard				Alice	Taylor					
Maryland	2 sho and Is ma		19a. Informant's Name/Relationship (Ty			ng Address (Street							
	and ealth m 27 her tr		Elsie Bussard / Wi	lie		Ferry La	anding Ci					/4	
ore	Jes 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce) Marc	h 14.	20c. Loca	ation - City or To	own, State		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amortant: in Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ODC9.		21. Signature of Funeral Service License Magalette Bang		M01305 R030	2. Name and Addre bert A. Pun O West Mont	ess of Facility Tiphrey Fune Egomery Ave	ral Home/ nue, Rock	Rockvi ville,	lle, Inc Maryl <i>a</i> nd	20850-	-2805	
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F	Physician		Immediate Cause (Final disease or condition	Meta	Static le	une cay	4 Cl				Onset and	Death	
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ğ	equire en sig	ed t	Neyfravenic	peres				1/2	Yes 2□	No 3 ☐ Prol	bably 4□	Unknown	
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Ä	The law ate has b page 2 st	mo						auto perfo 1□ Yes	ormed?	death? 1 ☐ Yes	mpletion of a 2□ No	ause of	
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Sic	Attending r death. ector: After y the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	29a Place of inju	ry - At home, farm, st		Yes 2 □ No	006 1	04	N 1 2			
Division	i or A after o Direct	Certification:	4 ☐ Homicide determined	building, etc	(Specify)	eet, factory, office		City or To		Number or Run	ai Houte Nur	nber,	
	Hospital 24 hours Funeral etely filled	2	29a. Certifier 1 Certifying Phy	sician: To the best o	of my knowledge, deat	h occurred at the ti	me, date and place	and due to the	cause(s) a	nd manner as s	stated.		
	e Hos 24 h e Fui	Medical	(Check only 2 Medical Exami	iner: On the basis of and manner sta	examination and/or in	vestigation, in my	opinion, death occi	urred at the time	, date and p	place, and due t	o the cause((s)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier	1	*	29c, Licens			29d. Date	signed (Month,	Day, Year)		
	0	15	Mu 1 Ch	much		291	417		Mari	LII,	2007		
1	14		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type,	1							
0	, '		AVAN S-CHANAIRS	1514	r JHADY	OREVE	140 P	rckvill	EM	40 20.	0.18		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVAIN C-CHANAGE ISVLS JHADY ORIVE PO RUCKU tate MAR 1 5 2007 MAR 1 5 2007											
	Regist	rar	MAR 1 5 2										

		1	For	partment of Health and Nertificate of Death		ene 007 08096
	Physicia		Decedent's Name (First, Middle, Last) JACK	BLUMENTHAL	2. Date of Death Month	Day Year 11: 45 P M
	/Medic Examin	al -	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	LXamiii		LEVINDALE HEBREW HOME	BALTIMORE		N/A
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 133-01-1076 7. Age (In yrs. last birthda 15 F 7. Age (In yrs. last birth	Months Davs Hours Min.	8. Date of Birth (Month, Day, Y 08/09/191	9. Birthplace (State or Foreign Country) NY
	ס		Usual Residence of Decedent 10a. State	Location	15.57 7 2	10d, Inside City Limits
	Aarylau Fahov	٥	DA1 TT			1 ☐ Yes 2 ☐ No
	r 28a-	Irect	MD N/A BALIIM 10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?
	ath wit	ralD	2434 W. BELVEDERE AVENUE	21215	pacifu Vac or No-	BALTIMORE 14. Race - American Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow appring righty or other traumatic event. The Modical Exertifier in arminative notified a page.	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Given Year or Dates:	 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: 	o Rican, etc.)	Black, White, etc. Specify: WHITE
2-0	"natur	leted	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work s. DO NOT use retired)		b. Kind of Business/Industry
21215-0036	withir jiene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ESMAN		GROCERY
pu	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	niden Sumame) TURITZ
Maryland	should nd Men marke imatic	2	19a, Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Ru	ıral Route Number, (City or Town, State, Zip Code)
, Ma	and 2 sauth ar n 27 la er trau			ATRIUM COURT #368		
Baltimore,	Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition 1 String Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	3/2007 OW	INGS MILLS, MD	
Balt	permit. Departimont. Import. any inj		21. Signature Funeral Service Licensee	22. Name and Address of Facility SO 8900 REISTERSTOWN	ROAD - PI	KESVILLE, MD 21208
J.	Pnysician			enter the mode of dying, such as cardiac	rction	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):		> 6 months	
	D =	ner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	rterry disease		
S.	ate be executed hysician and the burial-transit	Examiner	Cause (Diseese or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):			
	sate be shysicia the bur	cal	d			
.O. Box 68	he death certificate the attending phys thed for use as the	Physiclan/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
Δ.	The law requires that the de ate has been signed by the a bage 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the Hypertension, Dementia		23e. Did toba	acco use contribute to the cause of death?
of Vital Records,	w requir s been s should	Completed	Chronic penal failure	, ,	24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Re	The lav	omo	OVITATION		autopsy perform 1 Yes 2	ed? death? Order Order Order
/ita	Phyaician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		ath (Check only one	
	Physe this ral di	n: To	27 Manner of Death 28a. Date of Injury 28b. Tim	tient 3 DOA 4 Nursing F	dome 5 ☐ Resider 28d. Describe hov	nce 6 Other (Specify) v injury occurred
ion	or Attending Fatter death. Director: After in by the funer.	atlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		0.10.11
Division	after de Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, (Check only one) 2 Medicel Examiner: On the basis of examination and/one and manner stated.	eath occurred at the time, date and place or investigation, in my opinion, death occu	e, and due to the car urred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier Relieve MD	29c. License number D 0 0 5 3 9 2 8		d. Date signed (Month, Day, Year)
•	以		30. Name and address of person who completed cause of death (Item 23a) (Tr	(Pe, Print) SURAIYA BI		
	St	ate	31. Date filed (Month, Day, Year)	raile		
	Regist	rar	MAR 1 5 2007 Fleder St. 19			

4		State of Marylan 23a, 25, 27, 28a			_	_	08007
1-	Registrar		Certifica	ate of Death'	Re	g. No.	00001
	ecedent's Name (First, Middle, Las	(1)			Date of Death Month	n Day Year	3. Time of Death
Physician // /Medical //	Dorothy	Citro			O3	13 2007	11:00 PM
	acility Name (If not institution, give	street and number)	4b. C	ity, Town, or Location of Dea	th	4c. County of Death	
Jo	has Hopkins Ba	yview Medica	Center	Baltin	ire	N/A	
Funeral 5. So	ocial Security Number 6. Se	ax 7. Age (In yrs.	last birthday) If Un	der 1 Year If Under 24 Hr	S 9 Date of Birth	Year) 9. Birth	place (State or Foreign intry)
	0-24-4801	□M 2 8 F 8	3 Yrs.	3, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	(Month, Day, 8/8/192	23′ Mary	·lánd
0	al Residence of Decedent State 10b. County	10c Cit	y, Town or Location				10d. Inside City Limits
shoring 10g	,						1 XYes 2 No
M ed Ma		В	altimore				
Nith the Mark to r 28a-f si Director	Street and Number			Zip Code	10	g. Citizen of What Cou	intry?
inter death with the Maryland ritems 23a or 28a-1 show older must be notified at 10°. Funeral Director	3701 Frankford /			21206		USA	
ep a mun 11. M	Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was De	cedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
S aff	Never Married 2 Married 3XXWidowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	1 ☐ Yes	S XXNo Specify:		Specify: Whi	te
1 21215-003(led within 72 hours a vyjene. her than "natural", on the Medical Example. Completed by	15. Decedent's Ed		16a. Decedent's U	Isual Convention	1.	6b. Kind of Business/li	
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Mith Sales	ementary/Secondary (0-12)	College (1-4or 5+)	Homemak			Own Home	
D 20 17. F	Father's Name (First, Middle, Last)		110111011101	· · · · · · · · · · · · · · · · · · ·	ımə (First, Middlə, M		
d be fill the lifton Lee Jacks	son		Margar	et Westerr	nan		
Maryland 21215-0036 at 2 should be filed within 72 hours att at 2 should be filed within 72 hours att the and Mental Hygiene. 27 is marked other than "natural", or treumatic avant, the Medical Exami To Be Completed by F	. Informant's Name/Relationship (7	City or Town, State, Zi	n Code)				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dependent: Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dependent: It itsm 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic avant, the Medical Examinat must be notified at once. To Be Completed by Funeral Director To Be Completed by Funeral Director	athleen M. Citro	•	_	ankford Ave.		•	,
The Harman State of Soar	Method of Disposition	20b. F	lace of Disposition (Name of		0c. Location - City or T	own, State
Baltimore, permit. Pages 1 ar Deperment of Hea mportent: it itsm my injury or other page.	1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	emetery, crematory	1	7/2007	Sanator # 17 a	Maralland
Time Train 1	Signature of Funeral Service Licen		rkwood Cer	IIETERY 3/1	7/2007	Parkville. Itimore, MD	Mary Land
B Depending Suppose The Part of The Part o	Male	24	7072-15-22	ard J. Ruck,			
23a	Part 1 Enter the disease or comm	plications that caused the deat					Approximate
Imm	 Part1. Enter the disease, or comp shock, or heart failure. List only onediate Cause (Final 	one cause on each line.	Head Tra	auma S/p Fall		1	Interval Between Onse no Death
Physician dise	ease or condition ulting in death)	a_ Stroke	>	John /p rail			nours
Examiner		Due to (or as a conseq			[d]		500
Sequi if an	uentially list conditions, by, leading to immediate	b. Due to (or as a conseq		rebral Hemorr	hage ///	7	6 hours
caus E Caus	se. Enter Underlying	550 10 (0. 20 2 001.004	· ·	l Hematoma	4/1	PI EXAMINER	6 hours
m and transit that result that	initiated events ulting in death) Last	c. Due to (or as a conseq		. Houseons	WED BY M	EDICAL	O HOULD
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ficate ficate s the s the		d.		CERTIFIC			
Box 68 auth certificat entending phy for use as th for use as th clan/MedI	EMALE: . Was decedent pregnant	23c. If yes, outcome of pregna	incy			23d. Date of deliv	/ATV
Clar for all	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		pregnancy (specify)		Month	Day Year
P.O. hat the d detached Physi	1 Yes 2 No 9 Unknown	9☐ Unknown		1-7//			
ds, P.O. Box 68 ires that the death certificat signed by the ettending phy the detached for use as the	II. Other significant conditions of	ontributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
d begin a					1 ☐ Yes	s 2 No 3 Pro	bably 4 Denknown
al Record The law require cate has been single page 2 should Completed					24a. Was an	24h Wara aut	ansy findings available
mp ——					autopsy	prior to co	opsy findings available ompletion of cause of
					1 ☐ Yes 2	ØNo 1□ Yes	2□ No
Vita	Was case referred to medical examiner?	Hospital:		Othor	eath Check only one		
Physic of this of the control of the	1 XYes 25/No Manner of Death	1 UMnpatient 2 L	ER/Outpatient 3☐ 28b. Time of	4 Nuising	Home 5 Resider	nce 6 Other (Special of the control	(y)
Division of Vital Records, tel or Attending Physician: The law requires the safer death. Is after death. Is Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by the law of the safer law of the law o	Pending 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 03/13/2007	Injury	28c. Injury at Work? 1 ☐ Yes 2X No	broken si	idewalk. fel	1 hit head
tts death death the line	3 ☐ Suicide 6 ☐ Could not be		Unknown ^M		on concre	ete	al Pouto Number
Sin by affect of the principle of the pr	4 Homicide determined	building, etc. (Specif	y)	tory, onice	City or I own,	State) Interse ve. & Walt	ection of
points 29a	. Certifier 12 Certifying Ph	street ysician: To the best of my kno	wladge death occur	ed at the time, date and place	Baltimore	MD 21214	itel Ave.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certification to the Funeral Director: After this certificate has been signed by the ettending phycompletely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical or 12 and	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	tion and/or investigat	ion, in my opinion, death occ	urred at the time, da	te and place, and due	to the cause(s)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Signature and title of certifier			29c. License number	29	d. Date signed (Month,	Day, Year)
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20. 4		completed cause of down floor				ا ا ا ا	LUUT
li De	Kicknow Roma	46 700 EYS POLY	Save A	Baltimore, N	10,21224		
State 31. D	Name and address of person who of Kic4NDO Long. Date filed (Moirs Paul Year) 200	32 Registrar's Signa	ture frank				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) Anthony Salvatore Clavio 12 9:45 P March 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 12513 Kensington Lane Bowie Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 6, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1926 1**X** M 2□ F Pennsylvania 80 208–12–9227 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1**V**Yes 2 No Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12513 Kensington Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or DatesWW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Systems Analyst U.S. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paolo Clavio Carmella Migliaccio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20715 Norine A. Clavio / spouse 12513 Kensington Lane Bowie, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Vet. Cem. 03/15/2007 Crownsville, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelodysplasia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

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be o

iral", or items 23a Examiner must b

"natural",

27 Is marked other than ") traumatic event

Health a

Department of Health Important: If Item 27 any Injury or other to once.

Medical

Director

Funeral

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Completed

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Examir attending physician for use as the buria Physician/Medical Š Completed Be ၉ this After 1 Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed d in by the f within 24 hours aft To the Funeral DI completely filled in

Division or Vital Records, P.O. Box 68760

0 State

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Thrombocytopenia 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury 27. Manne of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

29c. License number 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D23743

March 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Center Dr. #205 Martin D. Weltz, M.D. Greenbelt, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

			1 - State Registrar	tate of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of I			ene 1. No.2 0 0 7	08099				
	Physici	an	Decedent's Name (First, Middle, Last)	1				2. Date of Death Month	Day Year	3. Time of Death				
	/Media	cal	Vennie Underwood 4a. Facility Name (If not institution, give stree		7	4b. City. Town or	Location of Death	March 7	2007 Year	10:30 PM				
	Examir	ier	Charlestown Care				nsville		Baltin					
	Funeral Director		5. Social Security Number 6. Sex 213–38–7111 1 □ M		96 (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Dec. 3,	9. Bird 1910 VI	hplace (State or Foreign buntry) rginia				
	land ow		Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits				
	e Mary	ctor	MD Baltimo	re	Ca	tonsville				1 ☐ Yes 2¶ No				
	with the or 28	Funeral Director	10e. Street and Number 719 Maiden Choice L	ano #P	D207	10f. Zip Code 21228		100	g. Citizen of What Co United					
	death ms 23	nerai	11. Marital Status 12. V	Was Decedent 6	ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	rican Indian,				
2-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or items 23e or 28e-f show imatic event, the Madical Examinar must be notified at	by	1 Never Married 2 Married	I □ Yes 2X N f Yes, Give Year or Dates:	lo	1 ☐ Yes X No	Specify:	rican, etc.)	Black, Whit					
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37	2 should and Mer te marke aumatic	2	Samuel Lee Underwoo 19a. Informant's Name/Relationship (Type, I	Selle Tho	Mas City or Town, State, 2	Zip Code) 21228								
	is 1 and 2 should of Health and Men item 27 te marke other traumatic		Mr. James Reginald C	osby, H		Maiden C	hoice Lar	ne, #BR20						
altimore,	Pages 1 nent of Hi int: if iter iry or oth		20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	ch 13,2007	20c. Location - City or Town, State , 2007 Timonium, Maryland									
Balti	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licensee	ian T. Chis	holm Funera L., Timonium	L Services of MD 21093								
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused	the death. Do not ent					Approximate Interval Between				
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		3	eneut	id			Onset and Death				
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ō	g Physer this seral dii	n; To	27. Manner of Death 2	i ∟inpatier Ba. Date of Injur	y 28b. Time o	28c. Injury	at Nursing Ho	me 5 Resident	ce 6 Other (Sperinjury occurred	cify)				
DIVISION	E & . E.	catio	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day			res 2□No							
<u>></u>	2 th := c	Certification;	4 Homicide determined 2	Be. Place of Inju building, etc	iry - At home, farm, str : (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,				
	To the Hospital of within 24 hours all To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) Certifying Physicia 2 Medical Examiner:	n: To the best of On the basis of and manner sta	examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)				
)	To the within 2 To the complete	W	29b. Signature and title of certifier	ell i	e #	29c. License	C 216	41	Date signed (Monta	7 - 7				
5			30f Name and address of person who comple	eted cause of de	eath (Item 23a) (Type,	Print)	puc (and Cu	Marson	ely Ma				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	2		,		21228				
	3.00		MAR 1 5 2007	1 Tomber	9-1 LS. 14	The same of the sa								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- Registrar State of Maryland / Department of Health and Mental Hygiene 1- Registrar State of Maryland / Department of Health and Mental Hygiene 1- 29d per dr Certificate 03/15/07dhb Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 13/ a M **₩**Thomas Dipietro 3 V mar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Center 5. Social Security Number 505eda If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F October 17 1929 Baltimore, Maryland 217 26 8776 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Baltimore Kinasville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21087 USA 11612 Cedar Lane 12. Was Decedent Ever in U.S. Armed Forces? 1XXVes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck driver Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Juliano Pasquale DiPietro ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11612 Cedar Lane Kingsville, Maryland 21087 Joan M DiPietro Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XXBurial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery Baltimore Maryland March 7 2007 4 □ Donation 5 □ Other (Specify) 21. Og tur of Funeral Service Lice see 22. Name and Address of Facility 11750 Belair Road EF Lassahn Funeral Home PA Kingsville, Md. 21087 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 16 (csd **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner De Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, 400) as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe certificate 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[V]No 1 Inpatient 2 ☑ ER/Outpatient 3 DOA ို 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 2 ☐ Medical Exa (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year)
March 5, 2007 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, 32. Registrar's Signature filed (Month, Day, Year) State MAR 1 5 2007 Registrar

		•	For State Registrar	State of Ma	•	epartment of He Certificate of D		fental Hygie _{Reg.}	211111/	08101
.55 '8'	F. 24	à	1. Decedent's Name (First, Middle, Las.					2. Date of Death Month	Day Year	3. Time of Death
П	Physici /Medic			Doris Er	nily Dhil	lon			12, 2007	7:00 a. [™]
	Examin	15.	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Death		4c. County of Death	
~			230	02 Westchest	er Ave			onsville		ltimore
	Funeral			X 7. Ag	e (In yrs. last birtl	day) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye February 8,	9. Birth Cou	place (State or Foreign intry) Ohio
- Že	Director		277-20-2302 Usual Residence of Decedent	, -	83			1 ebidary 0,	1324	Onio
	/land		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Many Perfeh	ţ	Maryland Bal	timore		Ca	tonsville			1 ☐ Yes 2 No
	r 28c	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	23a c		2302 Westchester Ave				21228		Ų.S	S.A.
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28e-f ahow other treumatic event, its Marical Examiner must be multipled at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2016 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	Specify:	,	Specify:	White
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7	filed withi Hygiene. other than	E	Elementary/Secondary (0-12)	College (1-4or 5	0+)	Teach	er / Writer		Luc	odtion
	i Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Mai	den Sumame)	
<u>a</u>	Mental Mental arked o	To B	Seymour	Thompson				Ruth	Peterson	
Maryland	2 should I and Meni Is marke eumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b.	Mailing Address (Street ar	nd Number or Rur	al Route Number, C	ity or Town, State, Zi	ip Code)
	1 and 2 Health a tem 27 Is		Mr. Raghbir S. Dhillor	n Husba	and	2302 Westche	ster Ave Ca	tonsville, Mary	land 21228	
ore	of He fitem roth	3	20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐		20b. Place of cemetery	Disposition (Name of r, crematory or other place) !	Date 20d	c. Location - City or T	Town, State
Ĕ	Pages ment of ant: If it ury or o		4 Donation 5 Other (Specify		/13/2007	Sykesville	e, Maryland			
Baltimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licen	R A N	- D A					
_	20 E # 0		Mullington	enont	MUICE	² 3871 O	uneral Home Id Columbia	Pike Ellicott C	ity, MD 21043	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each li	the death. Do n	ot enter the mode of dying	, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	probable	acute bo	mman	emboli	sm	
1	/Medical Examiner		leading in death)	Due to (or as	a consequence of	n):	()	emboli is		
Ü,		i.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	man Th	LOW WOI	11		
V	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury		'					
· ~	execu n and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence o	f):				
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9	tifica ng ph as th	Medi	IF FEMALE:							
Box	th cer tendir r use	an/N	23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal death	3 Ectopic pregnancy			23d. Date of deli-	very Day Year
П	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death	5 Other (specify)			Month	Day Feat
<u>а</u>	hat th od by detacl	Ph	Part II, Other significant conditions co	ontributing to death h	out not resulting in	the underlying cause give	n in Part I	23e, Did tobac	co use contribute to	the cause of death?
ds,	signe d be	d by	recent subtotal col	ections and	calustm.	forcolon be	rtuation	n 1 Yes	2 XNo 3 Pro	bably 4 Unknown
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jon	nding ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ly rear/		es 2 □No			
Division of Vital Records,	r Atte er de recto	Certification:	3 Suicide 6 Could not be determined	288. Place of III	jury - At home, far ic. (Specify)	m, street, factory, office		28f. Location (Stree City or Town, S	at and Number or Ru. State)	ral Route Number,
	ital o urs aft rel DI								,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical			of examination and	death occurred at the time Vor investigation, in my op				
	To the within Fo the comple	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month	n, Day, Year)
)	F- > F- 0		M. y	Car Gane	Louin		33211-		3/12/	107
	i.		30. Name and address of person who	completed cause of	death (Item 23a) (Type, Print)	- 0 - 10			
_	6		Bernitac. Taylor	mo 700	beine Rd	sterou Cat	minle	Md 211	128	
450	Sta		31. Date filed (Month, Day, Year)	32. R	rar's Signature	1		·		
₹.	Regist	ar	MAR 1 5 2	007	you At	43342				

07-01824 Robert Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day March 8, 2007 Year 0417 hrs Medical Examiner Robert Douglas Davis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12 1/2 Edmondson Ridge Road Catonsville **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Director Months Days Hours Aug. 23, 1963 MD 43 213-50-1822 1 XM Country) 2 Usual Residence of Decedent iny 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 Yes 2 XNo Baltimore Catonsville hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21228 United States 125 Edmondson Ridge Road 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? White, etc. 2 X No Yes If Yes, Give Year or Dates: Divorced Yes 2X No specify: Specify: White nt of Health and Mental Hygiene.

1: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Pages 1 and 2 should be filed within 72 Baltimore, MD 21215-0036 Self Employed Equestrian 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Quillian J. Davis Thelma Ann Armiger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 19a. Informant's Name/Relationship (Type, Print) 12½ Edmondson Ridge Rd., Catonsville, MD 21228 Ann Davis - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Lorentame of Park X Burial 2 Cremation 3 Removal from State Cemetery 3-15-2007 Woodlawn, MD Denation 5 Other Specify 22. Name and Address of Facility Ambrose Funeral Home, Inc. Arbutus, MD Sulphur Spring Rd., Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Asphyxia Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit sician/Medical X UNPENDED attending physician or use as the burial ^A#**E**\$3**6**,27,28a-f, per ME, g865, 3/17/07 TT The law requires that the death certificate be Box 68760, 23d. Date of deliver 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Yea Month Live birth 2 Fetal death Day past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the P.O. been signed by thould be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 examiner? Other Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Ves 28d. Describe how injury occurred subject accidentally asphyxiated 28a. Date of Injury 27. Manner of Death 2Bb. Time of Injury 28c. Injury at Work Certification: Natural 5 Pending 1 Yes 2 X No Fnd 3/8/2007 Fnd 3:15 am self 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 1/2 Edmondson Ridge Catonsville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide (Specify) found in residence Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. March 8, 2007 ull 1 1assel 30. Name and address of person who completed bluse of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mélissa Brassell, MD Date filed (Month, Day, Year 32. Redistrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

JAMES W. FABIAN

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NK UNK		- For State	ate of Maryla		irtment of <i>tificate of</i>		Mental		200 teg. No.	7 08103
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Medical Examina		James William F. 4a. Facility Name (if not institution	abian	mber)		b. City, Town, or I	ocation of De	March 6, 2	4c. County of Dea	
		11 Wann Ave	i, give the condition			Brooklyn			Anne Arund	el
Funeral	- 1		6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. I For	eign
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any	_	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits
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Baltimore, MD 2's permit. Pages 1 and 2 should Department of Health and M Important: If item 27 is an injury or other traumatic entermedical.		Rosemary B. Fab		r					ore MD 2122	
re, N Land Health Fitem er trau	1	20a. Method of Disposition 1 Burial 2 X Cremation	3 Pemoval fr	20b.	Place of Disposi crematory or oth	tion (Name of cen er place)	netery,	Date -13-2007	20c. Location - City	
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Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr	(1	21. John ure of Funeral Service	70106	nop					neral Home .ansd <u>owne M</u>	of Lansdowne
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876 tificate ng phy as the t	Ě	F FEMALE: 23b. Was decedent pregnant in the past 12 months?		outcome of preg irth	w/77.773	tal death 3	Ectopic pre	egnancy	Month Month	Day Year
Box 68760, c death certificate be the attending physic od for use as the burn	Physician/M		4 Pregn	ant at time of de	eath 5 Ot	ner (Specify)			,	
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cords, law requir has been s	Completed							24a. Was		autopsy findings available to completion of cause of
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Divis pital or At ours after of eral Direc filled in by	Certification:	3 Suicide 6 Coul	ld not be	e of Injury - At h		et, factory, office b	ouilding, etc.	or Town.		Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire tely filled in b		4 Momicide 29a. Certifier Certifying P	hysician: To the bes	st of my knowled	dge, death occur	red at the time, da	ate and place,	and due to the cau	use(s) and manner as s	stated.
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	(Check only one) 2 ✓ Medical Exa	miner:On the basis and manner s	of examination	and/or investiga	tion, in my opinior	, death occur	red at the time, date	e and place, and due to	the cause(s)
F 3 F 8	ĭ	29b. Signature and title of certific	er	7		29c. Licens			29d. Date signed (March 7, 2007	
(1)		Let Il	1771	on of dooth (II-	n 23a)				1	Inc
(V)		30. Name and address of person Zabiullah Ali, M.D.	who completed cau Assistant Med ic			ın Street, Balt	imore, MD	21201		
Sta	ate	31. Date filed (Manth, Day, Year)	2007 Z.R	egistrar's Signa	ture /	the s				

ORIGINAL

			for State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment <i>rtificate</i>			nd M		giene Reg. No.	007	08104			
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	/Medi Examir		4a. Facility Name (If not institution,			4b. City, T	own, or L	ocation of	Death		_	unty of Death	Control of			
			50. MD. HOSP. 5. Social Security Number	CENTER 7. Age	(In yrs. last birthday)	If Under 1	NTO	If Under 2	4 Hrs	9. Date of Die		INCE	GEORGE			
п	Funeral Director		N/A	1□ M ¾C F	Yrs.		Days	Hours	Min. 45	8. Date of Birt Month, Da	y, Year)	MA	place (State or Foreign intry) PULANID			
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	Aaryla f shov	ō	10a. State 10b. County		10c. City, Town or Le								10d. Inside City Limits 1 XYes 2 No			
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36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is merked other then "naturel", or Items 23e or 28e-f show or other treumetic event, I'm Medical Evanfrer must be rediffied at	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2	No K	Specify:			Sp	ecifyBLAC	K			
21215-0036	72 hou	ted	15. Decedent's	Education	16a. Dece	dent's Usual kind of work	Occupati	ion	of worki	-	16b. Kind	of Business/Ir	ndustry			
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Baltimore,	Pages nent of H int: If ite		1 ☐ Burial 2 ☑ Cremation 3		cemetery, crea	matory or oth	er place)	- 1				on - City or T				
ati	그 돈 말 글		11.0	4 Donation 5 Other (Specify) CHESAPEAKE CREMATORY 3-14-07 BELTSVILLE, MD. Signature of Funeral Service Licensee 22. Name and Address of Facility CAPITOL MORTUARY INC.												
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	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filted in by	Medicai	29a. Certifier (Check only one) (Check only one) 2 ☐ Medical Ex	Physicien: To the best of eminer: On the basis of and manner stat	examination and/or inv	occurred at restigation, in	the time, my opin	, date and p nion, death	olace, a occurre	nd due to the c d at the time, d	ause(s) and late and plac	manner as s ce, and due to	tated. o the cause(s)			
	To the within 2 To the comple(Σ	29b. Signature and title of certifier	201116	0		icense n			2	29d. Date sig	ned (Month,	Day, Year)			
c	7		30 Name and address of	a completed course of	~~ Mil	J	D332	268		3	3-7	-07				
0	1		30. Name and address of person who	NARER.	1503 Suj		5 R	2D (Lin	VTON.	mo.	2077	35			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 5 2	32 Aegistrar	's Signature	A)							-			

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Margaret Claire Fischer 5:00 a. March 14, 2007 /Medical 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard 7333 Eden Brook Dr. If Under 1 Year | If Under 24 Hrs. | Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Days Hours 1 ■ M 2 X F 77 July 4, 1929 New York Director 116-22-2954 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28e-f show other traumatic evant, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 21046 7333 Eden Brook Dr. U.S.A. by Funerai death v 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or its may njury or other traumatic event, the Madical Examires and. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Healthcare Elementary/Secondary (0-12) College (1-4or 5+) Nurse 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) Be Thomas Francis Counihan Anne Whalen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7333 Eden Brock Dr. Columbia, Maryland 21046 Mr. Carl Fischer, III Son 20a. Method of Disposition

1 □ Burial 2 ② Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 0 Baltimore, MD **Bayyiew Crematory** 22. Name and Address of Facility Slack Funeral Home, P.A 23a. Part 1. Enter the disease, or complications that dadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MIMOU disease or condition resulting in death) y ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic oregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) □Yes ed by the a Division of Vital Records, P.O. 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 2 X No 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 2 No 1 🗌 Yes Certification: To 2 ☐ ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural Injury 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 12 Certifying Physician: To the best of trip knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated, Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature/and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34613 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geller, Steven A. MD 8186 Lark Brown Rd. Suite 201 Elkridge, MD 21075 31. Date filed (Month, Day, Year) State MAR 1 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For Stete Registrer Certificate of Death 2. Date of Death 3. Time of Death **Physician** 0.47 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 1104 MOVE 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 220-92-254 1 ☐ M 2 ☐ 39 Director Usual Residence of Decedent filed within 72 hours atter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if of Health and Mental Hygiene. If item 27 is marked other than "naturel", or iteme 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 res 2 No **Funeral Director** ND timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21239 STON AVENUE Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. Yes 2 No f Yes, Give rear or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Blac Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Anale ears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jermit Pages 1 and 2 st.
Department of Healthingordant; if Itement injury cancer. Rato-MD 21239 Date 20a. Method of Disposition Burial 2 Cremation 3 ☐Removal from State 07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Services lun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician Breast Concer 8 yzars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physicien Certification; To Be Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day igned by the ette in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 Do 3 Probably 4 Unknown page 2 should peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes certificete 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours e To the Funerel C To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Physician March 13, 2007 5 3275 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MD NGUYEN Dissili

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 15

2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death T: 20AM seter 0.3 H 07 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Baltimore Hospice Imonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10 03 103 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days 213.32.5878 1 XM 2□ F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NIA Ba Imore 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? South Spring 2123 LLSA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tlectrical 2th grade technician 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kuben latha Kobunson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Batto. MD 21204 Brother Hamson Geter Menue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Woodlawn Woodlawn MD 4 ☐ Donation 5 ☐ Other (Specify) 031 15 07 21. Signature of Funeral Service Licensee Vauchn C. Greene Fusieral soucs 49.05 York Koad Bootto MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a. COLON CANCER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month 4☐ Pregnant at time of death 9☐ Unknown Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? /es 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ★ Other (Specify) HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 🔲 Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Tertifying Physiciam. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

/Medical Examiner attending physician and for use as the burial-trar or Vital Records, P.O. CHARLES GETER

Director:

Physician/Medical Examiner

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Completed

Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

Director

Funeral

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Be Completed

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

2007

MARCH

Baltimore,

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumaffic event, the Medical once.

Physician

State Registrar

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

2300 DULANEY VALLEY RD. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State	of M	larylan		artmen e <i>rtificat</i>				ental Hy	giene		0810	8
	Dhysiai		1. Decedent's Name (First, Middle	e, Last)								2. Date of De Month	Day	Y Year	3. Time of Deat	;h
	Physici: /Medic			Rita	S.		dstein					March		2007 Year		Ρм
	Examin	er	4a. Facility Name (If not institution		number)		4b. City,		Location				County of Death		
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	Funeral		5. Social Security Number 119-03-5444	6. Sex 1 ☐ M 2 ፟ F		89 89	last birthda Yrs.	Months	Days	Hours	Min.	Month, Da November	Year)	17 New	place (State or Fore intry) York	sigiri
	Director	}	Usual Residence of Decedent				-	1					. 09 13	727 1100	TOTAL	
	yland now		10a. State 10b. County			10c. Cit	y, Town or	_ocation							10d. Inside City Lin	nits
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	or 28	lire	10e. Street and Number					10f. Zip	Code				10g. Citi	izen of What Co	intry?	
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	r dea	Iner	11. Marital Status	12. Was De Armed	eceden Forces	Ever in U	.S. 13	. Was Deced	ient of H	ispanic Ori In, Mexicar	igin? (Spec	cify Yes or No Rican, etc.)	p-	 Race - Amer Black, White 		
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21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f show the Medical Examinat must be notified at	Completed by	3 Midowed 4 □ Divorced	Year or	Dates		160 Dos	edent's Usua	I Coour	ation			10h K	ind of Business/l	nductor	
<u> </u>	n 72	jete	15. Deceden (Specify only higher	st grade complete			(Giv	e kind of wo DO NOT us	rk done d	during mos	st of workin	g	100. K	and or pusinessy	ildustry	
12	thar thar	mo	Elementary/Secondary (0-12)	College	(1-4or	5+)	Off	ice M	anag	er			Rea	al Estat	е	
b	Hyg other	BeC	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
a	lid be fenta rked ric ev	To B	Leo Miller							An	na F	Kaplan				
Maryland	shou and N s ma		19a. Informant's Name/Relations	hip (Type, Print)			19b. Ma	ling Address	(Street a	and Numb	er or Rural	Route Numb	er, City o	or Town, State, Z	ip Code)	
Σ	and 2		Judith E. Golds	stein/Dau	ight						n Roa	d, #11	25,	Bethesd	a, MD 2081	14
ore	of He of He fiten		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 Memoval fro	m State	20b. P	lace of Dis emetery, cr	oosition (Nar ematory or o	ne of ther plac	e)	March	1 13.	20c. Lo	ocation - City or 1	Town, State	
<u>Ĕ</u>	Pag ment ent: I ury o		'4 □Donation 5 □ Other (S		III Otale	Mont	rgomery	Cremato	orium,	Inc.	2007		Bet	hesda,	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene amportent: If item 27 is marked other than "neture!, or items 23a or 28a-f show amportent: If item 27 is marked other than "neture!, or items 23a or 28a-f show amportent: If item 27 is marked or 18a-in and 18a-		21. Signature of Funeral Service	Supplied	/ M	01305	5 R	22 Name an Obert A 557 Wis	d Addres Pun consi	s of Facili iphrey n Avei	ity Funera nue, Ba	al Home, ethesda,	Beth Mary	esda-Chev land 2081	y Chase, In 4–3501	ıc.
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock/or heart failure. List only one cause on each line.													
	Physician		Immediate Cause (Final disease or condition a. PNEUNONIA													1
	/Medical		resulting in death)	Due t	o (or a	s a conseq		7 1011								
	Examiner	Sequentially list conditions b. JETOIO														
	ad sit	ine	Sequentially list conditions, it arry, leading to infinediate cause. Enter Underlying Cause (Disease or injury													
	and I-tran	Examiner	that initiated events resulting in death) Last	c	o (or a	s a conseq	uence of):								-	
8760,	cate be executed physician and the burial-transit	icai E			(
687	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit			d												
Box (seath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o				_						23d. Date of deli	very	
ă	death a atter	iclaı	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pre	gnant a	2 ∏ Feta at time of d		☐Ectopic pr ☐ Other (sp			<u>.</u>			Month	Day Year	
O.	t the coy the acher	hys	9 ☐ Unknown	9□ Uni	known								1			-
ď.	res that the de signed by the a i be detached f	by P	Part II. Other significant condition	ons contributing to	death	but not res	ulting in the	underlying c	ause give	en in Part I	l.	23e. Did 1	tobacco u	use contribute to	the cause of death?	?
Records,	w require been sig should b											10	Yes 2	∭ No 3⊟Pro	bably 4 Unkno	own
၁၁	e law re has be je 2 sho	piet										24a. Was		24b. Were aut	opsy findings availa	able
Ě	The ate he	Completed										perfo	rmed? 2∭ No	death?	2□ No	•
Vital	ysicien: The is certificate hi director, page	Be (25. Was case referred to medical examiner?						1.7	26. Place	e of Death	(Check only	one)			
Ž	Physic this call dire	ဥ	1 ☐ Yes 2 ื No		Inpat		ER/Outpati		-	4 140				6 □Other (Spec	ity)	
Ē	Attending Physicien: If death. ector: After this certification in the funeral director, by the funeral director, in	inol	27. Manner of Death 1 Natural 5 □ Pendin	9	te of Inj onth, D	ury a <i>y Year)</i>	28b. Time Injury		8c. Injury Work			8d. Describe	how injur	ry occurred		
Sign	tend death tor: / the f	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be	on of le	ium. At h		M	-	Yes 2 🗆		of Location /	Stroot an	d Number or Bu	ral Route Number,	
Division of	or All after of Direct	Certification:	4 Homicide determ	ined 286. Pla	lding, e	tc. (Specif	y)	treet, factory	, опісе			City or To			al novie Number,	
	To the Hospitel or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C		g Physician: To t Examiner: On the and m		of examina										
	To the within Fo the compl	Me	29b. Signature and title of certifie	r		•	~ ~		. License	e number				te signed (Month	, Day, Year)	
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_	, 1		30. Name and address of person	11												
	L		Alpana Goswami,			9 Roc		e Pike	e, St	uite	G-100	, Rock	vill	Le, MD 2	0852	
	Sta Registr		MAR 1 5		243		Mad	100								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM/106, perFH, G865, 3/15/07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician DORIS COHEN GOODMAN 8:30 AM March 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-03-2715 1 □ M 2 X F 94 MD Director 02/16/1913 Usual Residence of Decedent 10b. County N/A
NFW YORK with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits **NEW YORK** 1 Yes 2 No NY ns 23a or 28a-f sh must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 525 WEST END AVENUE 10024 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 7 Is marked other than "natural", or items traumatic event, the Medical Examiner m 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ARMED FORCES 12 SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARRY COHEN ELSIE KASDAN ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 WEST END AVENUE - NEW YORK, NY 10024 ELAINE EPSTEIN / NIECE permit. Pages 1 and Department of Health Important: If item 27 any injury or other troonce. 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/13/2007 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PI
23a. Part I Enter the elsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart ellure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Immedi re Cause (Final diseas or condition resulting in death) Acute **Physician** ailwre tenat 2 WKS /Medical Due to (or as a consequence of): Examiner 2 WKS Sepsis Sequentially list conditions, Due to (or as a consecuence of) Examiner If any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 WKS urosepsis the burial-trans Due to (or as a consequence of) ected month Physician/Medical decubitus wound Sacrym for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav 5 ☐ Other (specify) been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Sphagia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performe 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Delui Mo

MAR 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

29c. License number

TIMORE

D0053928

SURAIYA BELLUM, MD

29d. Date signed (Month, Day, Year)

03/12/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	State of Maryland / Departme State of Maryland / Departme Certifica	nt of Health and Mate of Death	lental Hygier	4001	08110
	Dharisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		Margaret C. Gosciniak		March 1	1, 2007	11:13p M
	Examin			y, Town, or Location of Death		4c. County of Deat	
				Rosedale ler 1 Year If Under 24 Hrs.	9 Date of Righ	Baltimor	re Co. hplace (State or Foreign
Н	Funeral Director		215-12-1640 11ÅM 2□F 83 Yrs. Months		4-2-192	ar) Co Man	untry) Cyland
	D .		Usual Residence of Decedent				
	anylar ehow	ř	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	ectc	MD Baltimore Co. Rosedale 10e. Street and Number 10f. Z	Zip Code	100	Citizen ol What Co	
	with with the correction of th	直	1521 Chivalry Court	21237	iog.	USA	unity :
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	edent of Hispanic Origin? (Sp.	ecity Yes or No-	14. Race - Ame	
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800	hours after death with the Maryland Lurel; or Items 23e or 28e-f ehow al Examiner must be notified at	d by	3X Widowed 4 □ Divorced Year or Dates:				
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D .		Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam-	e (First, Middle, Maid	den Sumame)	
<u>Jar</u>		70 E	Andrew Wisniewski	Clara K	ordonski	i	
Baltimore, Maryland 21215-0036	~ ~ ~ ~			ss (Street and Number or Run			Zip Code)
e) S	s 1 and 3 if Health item 27 other tr	1	Mildred C. Kalski - Sister 10805 Ho 20a. Method of Disposition (N	ward Terrac	e Beltsy	ville, N	ID 20705
פֿר	0 0		1 XBurial 2 Compation 3 C Removal from State cemetery, crematory of	r other place)			
돌				aus Cem. 3-			
B	permit. Deportuiport Import any inj			Dundalk Ave			MD 21222
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or hearf failure. List only one cause on each line.				Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition MYELO DYS PURS	>1 A			Onset and Death
	/Medical		resulting in death)				9 -
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Box	death certific e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic			23d. Date of del	ivery Day Year
о Е	0 0 0	Physician/Med	1 Tes 2 DNo 9 Unknown	specify)		WORL	Day 1961
م:	The law requires that the ite hes been signed by th page 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ds,	uires signe ld be	d by	Hy Co 1144 REIDISM		1 🗋 Yes	2□No 3□Pr	obably 4 Unknown
COL	w requires that been signed to should be deta	Completed			24a. Was an	24b. Were au	itopsy lindings available
æ	: The law cate hes t	omp			autopsy performed 1 ☐ Yes 2 ☑	prior to death?	completion of cause of
ita		Bec	25. Was case referred to medical	26. Place of Deat	h (Check only one)	140 12.63	20.40
<u>></u>	dir dir	2	examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3 [, ,	me 5 Residence	e 6 □Other (Spe	cify)
בי	ding Ph h. After th funeral	on:	27. Manner ol Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Injury 28b. Time of Injury	Work?	28d. Describe how in	njury occurred	
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Division of Vital Records,	i or Attenation after deati	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, lactor building, etc. (Specify)	лу, опісе	City or Town, S		irai Houte Number,
	Hospitel 24 hours 2 Funeral stely filled		29a. Certifier Certifying Physicien: To the best of my knowledge, death occurre				
	To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	edicai	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation and manner stated.	on, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	withi To t	Σ	29b. Signature and title of certifier	29c License number	29d.	Date signed (Monti	h, Day, Year)
•	~	10	setail IIIvo age para wo	1/2 = 1 002		rch 12,	
	12		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) A TUN M 12	(to Are	, Baltin	m, W7 21237
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 5 2007 32. Regirar's Signature				

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
AMEND TTEM#8, perFH, G865, 3/1/5/07, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** EMILY UDELL HYMAN MARCH 11 2007 8:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birt 0//19/1913e. Birthplace (State or Foreign Months Days Hours Min. 8. (Month, Day, Year) Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖵 F 93 Director 215-09-2633 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 130 SLADE AVENUE APT. #420 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. þ Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) ARLINGTON MONUMENT CO. College (1-4or 5+) **PROPRIETOR** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ABRAHAM MORRIS **ESTHER** FEINGOLD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HANNAH FLAKS / DAUGHTER 4422 CLYDESDALE AVE - BALTIMORE, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG↓03/13/2007 | REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Ther the flist as to or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart batter. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebral Vasc days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed? 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending Injury 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 057426 March 12. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) i0 Old Court Ro Pikesville Nonth, Day, 31. Date filed (Mo. State Registrar

07-01887

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amy Mareth Henderson 1- For State Certificate of Death Rea. No Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day March 10, 2007 0839 hrs Amy Mareth Henderson **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Howard Howard County General Hospital Columbia 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Foreign 49 Davs Hours 12/28/1957 Director Country) MD M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Prince Georges 1 Yes 2 X No MD Laurel "natural", or items 23a or 28a-f show | Examiner must be notified at once. permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9220-L 20723 Bridle Path Lane IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes White 4 Divorced If Yes, Give Yea 1 Yes 2 X No specify: Specify ₫. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Graphic Copier Arts 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles C. Henderson Eileen Hickev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eileen Henderson mother Baltimore, MD 10803 Symphony Way Columbia, MD 21044 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition ั ก **7** crematory or other place) Burial 2 X Cremation 3 Removal from State Sykesville, A 1 1 County Cremato Other Specify Donation 5 22. Name and Address of Facility Slack Funeral Home 3871 Old Columbia Pike Approximate Interval that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications **Physician** Between Onset and failure. List only one cause on each line. Modition Death Cardiac arrhythmia associated with chronic obstructive Immediate Cause (Final disease Examiner Due to (or as a consequence of): Julin hary disease or condition resulting in death) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED e attending physician for use as the burial -AMENDED 27, perME, g866, 4/26/07 TI Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of Other (Specify) Yes 2 No 9 V Unknown death Unknown After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ş Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 N 1 🗸 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be examiner? Hospital: DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No 5 Pending To the Funeral Director: completely filled in by the 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 11, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Margarita Korell MD.

31. Date filed (Month, Day, Year)

ORIGINAL

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Tyro

01971 one Jackson,	lr.	Please Type or Print in Black Indelible In State of Maryland / Department of		•	_		7 0011
one Jackson,		1- For State Certificate of		iu Mentarri	-	2001 g No.	/ USII.
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		·	2. Date of Death	1	3 Time of Death
dical Exami		TYRONE AARON JACKSON, JR	•		Month March 13,		0248 hrs
		Facility Name (if not institution, give street and number) Johns Hopkins Bayview	b. City, Town, o Baltimore	or Location of Death		4c. County of Death	'
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye Months Da			(MM/DD/YYYY) 9. Bin Foreig	
Director		215 19 6966 1XM 2F 19 Yrs. Usual Residence of Decedent	Months	lys Hours Iviiii.	NOV.9		untry) MD.
any		10a State 10b. County 10c. City, Town or Location	on				10d Inside City Limits
land f show	ē		BALTIM	IORE			1 Yes 2 No
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygene tt. If item 27 is marked other than "natural", or items 23a or 28a-f show any other traunuatic event, the Medical Examiner must be notified at once,	Director	10e. Street and Number 6513 BROOK AVE.	10f. Zip Code 212	06	10	g. Citizen of What Cour	ntry?
h with ms 23 be no	Funeral		Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,
er deat	F	A Never Married 2 Married 1 Yes 2 X No	Yes 2 X N		, , , , , , , , , , , , , , , , , , , ,		ACK
urs aftı tural"	à	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent'	's Usual Occupa	ation (Give kind of v		16b. Kind of Business/I	
5 72 hoi n "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working lif	fe. DO NOT use reti	red)	AUCO PUD	DED GO
5-0036 Hed within 7 Hygiene I other than	mp		MBLY W		AFTER BALLET BA	ATCO RUB	BER CO.
15-(Be C	17. Father's Name (First, Middle, Last) TYRONE A. JACKSON, SR.		18 Mother's Name	A CAWTI		
21215-00; ould be filed with a Mental Hygiene s marked other t ic event, the Me	To B		Address (Stre			per, City or Town, State	, Zip Code)
MD 21 d 2 should lth and Me n 27 is ma aumatic ev			BROOK			1D. 21206	T. O
ore, MD es 1 and 2 sho of Health and If item 27 is		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposit crematory or other		emetery,	Date	20c. Location - City or	Town, State
timent transition of or of		4 Ponation 5 Other Specify: GARDENS (OF FAT		.17,20	7 BALTIM	ORE,MD.
Baltimore, permit Pages I and Department of Heal Important: If iten injury or other tra		Molaco de Theresand CA				NERAL HOM	E 21212
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying	g, such as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Shotgun Wound of Torso					Death
		or condition resulting in death) Due to (or as a consequence of):					
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause					
ed	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
e executed cian and cial - transit	ical	UNPENDED AMENDED					
68760, certificate be nding physicise se as the buon	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	tal death 3	B Ectopic pregna	ancy	23d. Date of deliver	y Day Year
tox 687 eath certific eath certific attending p	sician/Med	past 12 months? 4 Pregnant at time of death 5 Oth	tal death 3 ner (Specify)		arioy		
Box he death c the atten hed for us	Phys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the ur	ndorlying cause	a civen in Part I	23e Did tol	pacco use contribute to	the cause of death?
ords, P.O. B w requires that the d is been signed by the should be detached	by	Part II. Other Significant conditions Contributing to dealth out not resulting in the di		s given in t ditti.		2 No 3 Prol	
rds v requi s been should	Completed				24a. Was a autops	sy prior to	utopsy findings available completion of cause of
Reco	omo				perform 1 Y Yes 2		es 2 No
tal Rection: The certificate ector, page	Be	25. Was case referred to medical examiner? Hospital: 1 Insertion 2 FBIOutpatient		Other			_
of Vital Records, ing Physician: The law requint Affer this certificate has been sumeral director, page 2 should the control of the control o	7	1 V Yes 2 No Impatient 2 ENOutpatient 2 Produpation 2 27. Manner of Death 28a Date of Injury 28b. Time of In		at Work?		Residence 6 Othe	r.
Sion Attendir r death ector: A	atio	1 Natural 5 Pending Mar 13, 2007 0230 hrs	1	Yes 2 V No			
iγ after d in	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family	et, factory, office	e building, etc.	or Town, St		ural Route Number, City d.
	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation	red at the time, tion, in my opini	date and place, and on, death occurred	d due to the cause at the time, date a	e(s) and manner as statend place, and due to the	ne cause(s)
To the within To the comple	Mec	29b. Signature and title of certifier	29c. Lice	nse number		29d Date signed (Mo	onth, Day, Year)
		(and Hallan	0.0	C.M.E.		March 13, 2007	
6		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn S	Street Raltin	more, MD 2120	01		
	tate	31 Date filed (Month, Day Year) 32. Redistrar's Signature					
3	ثللث	MAD 1 5 2007 Real Mr. A.	and as				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Edward Jones 9:45 a. March 12, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore 160 Sanford Ave If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

Months Days Hours Min. November 15, 1945 Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Maryland Yrs 61 Director 213-52-6682 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or than "natural", or Items 23a or 28a-f show the Medical Evantimer must be notified at 1 ☐ Yes 2 No Director Catonsville **Baltimore** Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 160 Sanford Ave. Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 ☐ Divorced 16b, Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than " Bartending Elementary/Secondary (0-12) College (1-4or 5+) Bartender 12 Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If Item 27 is marked o Lelia McGruther Weldon Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 Sanford Ave. Catonsville, Maryland 21228 Daughter Mrs. Karyn Bitzel 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Agremation 3 Removal from State
4 Donation 5 Other (Specify) 03/14/2007 Sykesville, Maryland All County Cremation Services, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 140123 Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cour cec Rectal **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physiclan/Medlcai e attending phy... IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ☐ Yes 2☐ No detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 3 Probably 1 ☐ Yes 2 0 No 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? has funeral director, page 2 autopsy performed? certificate 2 0 No 2 NO 1 Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturat 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident hours after deat uneral Director: 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 - Homicide 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical iCheck only onel and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** ARLENE SARAH KOZAK MARCH 13, 2007 10:25 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 K 219-28-1890 Director 72 JUNE 26, 1934 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 No Funeral Director BALTIMORE MD **GLENDALE** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6414 SHERWOOD ROAD 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 ∏Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: <u></u> Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC RELATIONS 12TH GRADE A & S TRAVEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK DI DONATO CATHERINE TAYLOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH KOZAK/HUSBAND 6414 SHERWOOD ROAD BALTIMORE, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 3/16/2007 CATONSVILLE, MD 4 ☐ Donaţion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chanic of struck disease or condition resulting in death) COV /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed as the burial-trans and Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 overin MEUMONIA Myocardia 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 has autonsy certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this P 28a. Date of Injury (Month, Day Year) funeral (27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: al or Attending F safter death. After 1- Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Box 68760. P.O. I Division or Vital Records,

3altimore, Maryland 21215-0036

To the Funeral Director: hours within 24

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

AMON

Utanias un 6701 W.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1)58303

29d. Date signed (Month, Day, Year)

march 14 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26 PM Day Month Year **Physician** osalina 2007 13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Q Town, or Location of Death Examiner 90Mer 05 Grove Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 □ M 2 🗷 F Months Hours 34-2964 New Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" ~ " any injury or other traumatic event." 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Bron 1 ■Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Bench 104 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 250 No Yes, Give 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🗖 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lerica erk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mar ere 7 059 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SISTER ace 120 en Ch ron 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town State 1

Burial 2 □ Cremation 3 ☐Removal from State -19-2007 Bronx, New 3 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 1425 Baltimore, Md. 21217 eten Culloh 1701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cordinasular diseas Atheroscleration **Physician** in Know disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transi P.O. Box 68760\$ aftending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy performed 2☐No certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Jittle of certifier M.D. 03-13-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)
MAR 1 5

2007

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 10, Physician 2007 rear 9:30 pM John J. Loewer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Manor Care Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) 5. Social Security Number **Funeral** 7/27/1917 Months Days Hours Min 1 X M 2 □ F Yrs Maryland 89 Director 217-09-0878 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐Yes 2 🙀 No Baltimore Parkville Directo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or other traumatic event, the Medical Examiner must be USA 21234 2504 Wycliffe Road Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No if Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Spice Manufacturing Pruduction Superisor 18. Mother's Name (First, Middle, Maiden Surname) marked other 17. Father's Name (First, Middle, Last) Be Katie Leonard Loewer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau <u>.00</u> Parkville, MD 2504 Wycliffe Road Maria Davis/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cem. 3/14/2007 Baltimore, Maryland Baltimore, MD 21214 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 5305 Harford Road Leonard J. Ruck, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examine The law requires that the death certificate be executed Due to (or as a consequence by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month 5 ☐ Other (specify) 9☐Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 20 No. Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 🗖 Naturai 1 Tes 2 Accident Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

5

oewer

DHMH 17 Rev 1/2001

Name and address of p

Ayman AKK 31. Date filed (Month, Day, Year) lowson, MD 21204

(Item 23a) (Type, Print)

7400 Osler Dr. #411

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 08:05 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** NIA -TIMORE MORE If Under 24 Hrs. MEDICAL CENTER 9. Birthplace (State or Foreign
Country)
M. Caro lina 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, /2-/4 If Under 1 Year Months Days 5. Social Security Number 6. Sex **Funeral** 215-24-3379 1 **∑**M 2 □ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic avenual. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 476s 2 No Funeral Director Saltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2/229 3807 Was Decement Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Z Never Married 2 Married I □Yes 2 □ No If Yes, Give Year or Dates: 1 Yes 2 40 Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) shoreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unkhown aura 19a. Informant's Name/Relationship (Type, Print) | 5 19b. Mailing Address (Street and Number of Rural Rune Number, City or Town, State, Zip Code) hd. 21133 8908 Johnson uber Kanda 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville 3-20-2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Service PJA Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medlcal use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 should be 2 No 3 Probably 4 Unknown DLVULUS 1 ☐ Yes ted Complet 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate To tha Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide after within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner staty. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 29c. License number

State Registrar

1 y

32. Registrar's Agnature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07-01964 Allan Long

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Medical Examiner 2135 hrs March 12, 2007 Alan Maurice Long 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dealt 3116 Harford Road Baltimore 5. Social Security Number 6. Sex 9 Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Foreign Min Director 2 Country) Usual Residence of Decedent 10a. State 10d. Inside City Limits any 10b. County 10c, City, Town or Location 1 Yes 2 No 28a-f show , or items 23a or 28a-f shor r must be notified at once. hours after death with the Maryland Director 10g Citizen of What Country? 10e. Street and Numb 10f. Zip Code Funeral 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, other traumatic event, the Medical Examiner must be White, etc Armed Forces? Never Married 2 Married Yes 4 Divorced If Yes, Give Year Yes 2 No specify: à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 tent of Health and Mental Hygiene item 27 is marked other than MD 21215-0036 18 Mother's Name (First, Middle, Maiden Surname Be State, Zip Code) Name/Relationship (Ti (Street and Number 20b Place of Disposition (Name of cemetery 20c. Location - City or Town, State Baltimore, crematory or other place) 2 Cremation 3 Removal from State Donation Other Specify permit Depart he disease, or complications that caused the death. Do not enter the r Approximate Interval **Physician** Between Onset and failure. In only one cause on each line /Medical Death Atherosclerotic cardiovascular discass Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X AMENDED #23a,PII,2/,perME, g865, 3/17/07 TT AMENDED #23a,PII,2/,perME, g865, 3/15/07 TT attending physician a X UNPENDED Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the I ive birth Fetal death Ectopic pregnancy Month Year detached for use as past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? P.O. signed b ģ 1 Yes 2 No 3 Probably 4 V Unknown Alcohol use Completed Records, peen page 2 should 24b Were autopsy findings available 24a Was an prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 2 No No 1 🗸 Yes director, 25. Was case referred to medical 26 Place of Death (Check only one) the Hospital or Attending Physician: of Vital Be Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 Other: Scene Inpatient ER/Outpatient 3 1 V Yes 2 To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 X Natural Division 1 Yes 2 No 5 Pending death Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicade Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier O.C.M.E. March 13, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Allen Theodore Leffer, II State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Medical Examiner 2250 hrs March 5, 2007 Allan Theodore Leffler, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Montgomery Rd & Chatsworth Court Ellicott City Howard If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Gountry) Kentuck Months Days Hours Min. 9/10/1940 76.44.3574 **478** 66 Director 1 M 2 F Yrs Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location 10b. County Ellicott city MD Howard 1 Yes 2 X No 'natural", or items 23a or 28a-f show Examiner must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygient and Propertment of Health and Mental Hygient of the propertant: If item 27 is marked other than "natural", or items 23a or 28a-f she
injury or other tranmatic event, the Medical Examiner must be notified at once Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4790 Montgomery Rd. 21043 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married White Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed Specify ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Doctor Healthcare 5 +18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allan Theodore Leffler Josephine Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Mrs. Melissa Leffler wife 4790 Montgomery Rd. EllicottCity, 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Bayview Crematory 1 Burial 2 Cremation 3 Removal from State 3/12/07 Balto., MD 4 Donation 5 Other Specify 22. Name and Address of FacilityS 1 a C k Signature of Fune al Service Licenses Funeral Home, 3871 Pike, Ellicott Old Columbia 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED erFH, g866, 4/5/07 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown ۵ Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director. the Hospital or Attending Physician: hin 24 hours after death. 26.Place of Death (Check only one) of Vital 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month Day Year) Mar 5, 2007 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Driver in auto auto collision Certification Natural 2236 hrs 1 Yes 2 V No Division Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)
Montgomery Rd & Chatsworth Court, Ellicott City, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie March 6, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death cedent's Name (First, Middle, Last) Day **Physician** 3 -07 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 110 North Central Ave 8. Date of Birth (Month, Day, Year) timor 4 Hrs. Min. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 218-22-6046 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 XYes 2 ☐ No Director Itimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or Nort Funeral Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event: the Mean Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type Pril Doughter 19b. Mailing Address (Street and Number of Aural Route Number, City or Town, State, Zip Code) Alameda Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition e of Funeral Service Licensee MO1363 Rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ola CANCER 2) KIGON /Medical Due to (or as a consequence of): Examiner majoraevic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 KNo 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. the 9☐ Unknown 9 🗆 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should neec 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Jas autopsy perform this certificate 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1□Yes 2√No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1.XNatural 2 ☐ Accident 28a. Date of Injury (Month, Day 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide after within 24 hours a To the Funeral D To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

MAR 1 5

MO

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** :50 PM 3 2007 MAR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPI Balti ablaMCY C Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Examiner must be notified Director altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) alesman Compader Industr ea15 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be seph MCNeil ဂ Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiverton Prd Pronobulistus

Name of Date 20c. Location otrice laylor mo 81133 20a. Method of Disposition 1 Disposition 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 □Removal from State loodlawn 4 □ Donation 5 □ Other (Specify) 03.19.07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voughn C. Greene Juneal Ferro 8728 Liberty Mood Mandellstan mo A11,32 Voughn C. Juene 8728 Liberty Phoad Phandle 23a, Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** A DENO CARCINOMA YEAR! /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a pansacularge off Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 0 signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division or Vital Records. 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. HOSPITAL. AGNES 3. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 15 Registrar

4

		1 - State Registrar	State of Maryland		rtificate of l		,	Reg. No.	2007	03	24	
Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month March	1 Bay	2007	3. Time of Dear		
/Medic	al	Anna M. Mauchl 4a. Facility Name (If not institution, give s			4h City Town or	Location of Death	March		2007 County of Death	1:15 P	М	
Examin	er	ManorCare Health	·			argo			rince G			
Funeral Director		5. Social Security Number 6. Sex 168–10–8605		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan • 7		9. Birth	place <i>(State or For</i> intry) Isylvania	-	
A 4		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Lir	mits	
-f sho	tor	MD Prince Ge	orge's	Ţ	Jpper Marl	lboro				1	ĴΝο	
or 28a e notii	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	intry?		
23a oust b	ral	16800 Clagett Lan			207				USA			
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.8 Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White				
atural cal Ex		15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind	d of Business/I			
Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired	during most of work f)	ing	g				
ygien ner th t, the	Con	10			Waitress				Restaur	rant		
even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	, , ,					
d Mer marke	은	Frank Kraus 19a. Informant's Name/Relationship (Type	ne Print\	19h Maili	ng Address (Street a		eth Eber			in Cada)		
lth an 27 is i		William C. Burkhar	,) Clagett				Marlbon		774	
item item othe		20a. Method of Disposition	20b. Pl	ace of Dispo	osition (Name of matory or other place	1 [Date		ation - City or T			
unt: If		1 X Burial 2 □ Cremation 3 X R 4 □ Donation 5 □ Other (Specify)	emoval from State	vania	Hills Cen	n. 03/1	7/2007	Roch	ester,	PA.		
Departr Imports any Inju		21. Signature of Funeral Service License	0	2	2. Name and Addres	ss of Facility Bea	all Fune	eral	Home			
0 5 2 0		Chuan	fowell_		5512 NW Cr				ryland	20715		
nysician /Medical xaminer		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	the	liomA			rest,	9	Approximate Interval Between Onset and Death	n in wh	
	-	Sequentially list conditions, b	. Due to (or as a consequ	ence of								
d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as a consequ	ence of):								
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)	,		23	3d. Date of deliv	very Day Year		
ned b e deta	by Pt	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death	1?	
en sig		tryperteusion					1 U Y	'es 2	ANo 3□ Pro	bably 4 □Unkno	iown	
ate has be page 2 sho	Completed	(.					24a. Was a autop perfor			opsy findings available on pletion of cause 2 \square		
ertific ector,	Be (25. Was case referred to medical examiner?			Tau	26. Place of Death						
this c	은	TLI res ZIXUNO	lospital: 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury	28b. Time o		4 Mursing Ho				ify)		
After funer	tion:	27. Manner of Death 1 Natural 5 Pending investigation	(Month, Day Year)	Injury	Worl	yat k? Yes 2 □ No	28d. Describe h	ow injury	occurred			
after deat I Director: d in by the	Certification:	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. Place of injury - At hos building, etc. (Specify	me, farm, st			28f. Location (S City or Tow	treet and n, State)	Number or Rui	ral Route Number,		
n 24 hours ne Funera oletely fille	Medical C	29a. Certifier (Check only one) 1	sician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, deat ion and/or ir	th occurred at the tin	ne, date and place, pinion, death occur	and due to the ored at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)		
withi To tl	M	29b. Signature and title of certifier	sele my		29c. License		1	29d. Date	signed (Month	, Day, Year) , 2007		
)		30. Name and address of person who co Alain Champaloux,	M.D. 14314	old I	Marlboro 1	Pike Up	per Mar	lboro	o, MD.	20772		
Sta Registr		31. Date filed (Month, Day, Year) MAR 1 5	32. Regionar's Signat	Jr ,	Sperke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1148 PM Si March Makulowich John 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months | 1**X** M 2□ F 63 141-34-5419 Director December 9, 1943 New Jersey Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12008 Golden Twig Court 20878 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🛛 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) National Institutes Elementary/Secondary (0-12) College (1-4or 5+) Of Health Communications Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alex Makul Ann Bogdanowicz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 of Health Gail Makulowich /Wife 12008 Golden Twig Court, N. Potomac, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of H Important; If Ite any Injury or ot once. March 15. 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 2007 4 □ Donation 5 □ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Service Eigenses 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Bai M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** taute Myscardia minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has page 2 s autopsy 1□ Yes 2 3 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient this (Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director; A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t ✓ Cerlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

25

State Registrar

DHMH 17 Rev 1/2001

Toel Buzz Mo ate 31. Date filed (Month, Day, Year) 9901 Medical Ce 32 Jegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Center Drive, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mary		Certificate o			2007	08126		
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Deet Month	h	3. Time of Death		
	Physicia /Medic		Doris Lucy	Myers				March	11, 2007			
	Examin	er	4e Fecility Neme (If not institution, give 804 Clearview A				4b. City, Town, or L Hampstea		4c. County of De	. County		
	Funeral Director		212 30 0003		n yrs. lest birti 58 Y	hdey) If Under 1 Ye. Months Day		8. Date of Birth (Month, Day, May 11,	^{Year)} 1948 Ma	irthplece (State or Foreign County) Iryland		
	lend W		Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits		
	Mery P-f sh	tor	MD Carr	oll		Hampstea	ıd			1 ☐ Yes 2 💢 No		
	ith the Meryler or 28a-1 show a notified at	Direc	10e. Street end Number			10f. Zip Code	Э	10	0g. Citizen of What	Country?		
	s 23a	rail	804 Clearview Ave				21074		United S	States nerican Indian,		
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Meryland Depertment of Heelth and Mental hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at page.	by Funeral Director	11. Marital Status 1 □ Never Merrled 2 □ Married 3 □ Widowed 4 🌠 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	rin u,s.	If Yes, specify C	of Hispanic Origin? (Si uban, Mexican, Puerto lo <i>Specify:</i>	Pican, etc.)	Black, Wi			
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16e.	Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret	cupation ne during most of work	king	16b. Kind of Busines	ss/Industry		
12	within ene.	Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)			red) Technician		Malco Pla	stics		
d 2	illed Hygi other	e C	17. Father's Neme (First, Middle, Last)			TIM LOD I		ne (First, Middle, M		IDCTCD		
ylar	should by nd Menta marked umatic ev	10 B	Joseph Percy Wa	rd			Lula (Sborne				
Mar	12 sho		19a. Informent's Neme/Reletionship (1			Mailing Address (Stre						
	Heelth elem 27 is other trau	- 1	Mr. Edward Myers, 20a. Method of Disposition		20b. Place of	622 Harewo Disposition (Name of			20c. Location - City			
Baltimore,	t. Peges tment of tant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		cek Church (lemetery (New Windso			
Bal	Deperminent Deperm		21. Signature of Funetal Service Licensee 22. Name and Address of Facility Harman Funeral Service M01113 7221 Grayburn Drive, Glen Burnie, MD 2									
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the one cause on eech line.	death. Do n	ot enter the mode of d	lying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final	1. 30 %	1691	0	A			Guera		
	Examiner		disease or condition resulting in death)	a. Due	e to (or es a c	onsequence of):				Check		
	D .ti	liner	_	b								
	ificete be executed g physicien end es the burial-trensit	edicai Examiner	Sequentially list conditions, if eny, leading to immediate	Due	to (or es e co	onsequence of):				† †		
68760,	re be e ysicier e buri	cal	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	C	to (or as a co	onsequence of):						
	<u> </u>	-	resulting in deeth) Last	d								
Box	d for u	Iclan	Part II. Other significent conditions co	ntributing to death but no	ot reculting in	the underlying cause	diven in Part I	23h Did to	hacco use contribu	ite to the cause of death?		
0.9	at the c	Phys	ath. Other significant conditions of	This daily to death but the	ot resulting in	and disderiying coust	giveirii i aici.			Probably 4 □ Unknown		
S,	res the	þ							. 041	Mana automo findingo		
Division of Vital Records, P.O	Attending Physician: The law requires that the death cen or death. ector: After this certificate has been signed by the ettendin by the funeral director, page 2 should be deteched for use	Be Completed by Physician/N						24a. Was ar perform		o. Were autopsy findings available prior to completion of cause of death?		
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ita	lan: T	Se C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one				
<u>></u>	Physical this ce	ဦ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Out	Datient 3L DOA			nce 6 □Other (Sp	pecify)		
N C	Ing Pl	ü	27. Menn of Deeth 1	28e. Dete of Injury (Month, Day Ye	par) 28b. Ti	jury W	ijury et Vork? □ Yes 2 □ No	28d. Describe ho	w injury occurred			
1 Sic	deeth ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	Zoe. Fleue of injuly	At home, fan	m, street, factory, offic				Rural Route Number,		
S	s after of Dire	Cert	4 Homicide	building, efc. (5	ipecify)			City or Town	, State)			
	To the Hospital or Attending Physician: The law requires that the deeth cerwithin 24 hours after deeth. To the Funerel Director: After this certificate has been signed by the ettendin completely filled in by the funerel director, page 2 should be deteched for use	Medical Certification: To		rsicien: To the best of m iner: On the basis of exa end menner stated.	minetion end							
	To the within 2	Σ	29b. Signature end title of certifier	uls M	U)	29c. Lice	35398	25	Date signed (Mo) $3 - 12$	nth, Dey, Year)		
5	1		30. Name and address of person who o	ompleted cause of deeth	(Item 23e) (T	ype, Print)	ter Stra	et 1 124	unister !	-07 D21157		
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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mary	•	tificate of			eg. No. 0 0	7 (08127
	Dhysisi		1. Decedent's Name (First, Middle, Las	•				2. Dete of Deet Month	h Day	Yeer	3. Time of Death
	Physici /Medio		ONAT ZHOO		N		4b. City. Town, or Loc	0.3	14	07	6.25 Pm
	Examir	er	4a Fecility Neme (If not institution, give	street and number)		ŀ	Baltimore	ation of Deeth	4c. County	or Deeth	
	F		Genesis Hamilton 5. Social Security Number 6. Se	x 7. Age (In	yrs. lest birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthpla	ace (Stete or Foreign
	Funeral Director		218-20-0855	□M 21X F 8		Months Days	Hours Min.	05/01/	1924	Minne	esota
	yland		10a. Stete 10b. County	100	. City, Town or Lo	cation				10	d. Insida City Limits
	Mar in-1st	ctor	MD N/A		Baltimore	9					1 X Yes 2 □ No
	ith th	Dire	10e. Street end Number			10f. Zip Code		1	0g. Citizen of V U.S.A		y?
	s 23a	erai	3111 Grindon Aven	12, Was Decedent Ever	in 11 S 12 V	21214	lienanic Origin? (Spe	city Ves or No-		America	in Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: if Item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumetic event, the Medical Examinal must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Yes, specify Cube	lispenic Origin? (Spe en, Mexican, Puerto F Specify:	Rican, etc.)		k, White, e	
5-0	72 hc	eted	15. Decedent's Ed (Specify only highest grad	ucation le completed)	16e. Deced	lent's Usual Occup	etion during most of working	ng	16b. Kind of Bu	siness/Indi	ustry
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/an	Antal be	To Be	George B. German				Dorothy	Archer			
Maryland	and N		19a. Informent's Neme/Relationship (7	ype, Print)			and Number or Rure		-		Code)
	and in 27 in 27 in the tr		Richard B. Oden,				Avenue, Ba				Ctato
Baltimore,	or of		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐			sition (Name of natory or other place			20c. Location -		
Ę	it. Pa intmar rhant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		1111top S	Name and Addre	poration 3, ss of Facility Le	/16/07 onard .1	Ruck	Inc.	Tanu
Ba	Deperment of the perment of the permet of the pe		Clavandria	Bakes	5	305 Harfo	ord Road,	Baltimo	re, MD	21214	
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Box (nding usa a			d	nay	Dolly	Dina				
	daath e atte ed for	Physician/M	Pert II. Other significant conditions co	ntributing to deeth but no	resulting in the u	nderlying ceuse giv	en in Part I.	23b. Did to	bacco use cor	tribute to	the cause of death?
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of Vital Records,	sician: The law certificate has b lirector, page 2 s	Be Co	25. Was case referred to medical				26. Place of Death				163 2510
fVi	Physicia this cer al direct	To B	examiner?	Hospital:	2 ER/Outpetien	t 3 DOA Oth	- /			er (Specify)
o uo	nding Ph ith. : After th e funeral	ation:	27. Menner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Injury (Month, Dey Yea	28b. Time of Injury	28c. Injur Wor M 1 🗀	y et 2 rk? Yes 2 □ No	28d. Describe ho	ow injury occur	red	
Division	or Atter after des Director	ertifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office	2	8f. Location (St City or Town		er or Rural	Route Number,
_	To the hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical Certification:	(Check only 2 Medical Exam	sician: To the best of my							
	ithin S o the ormple	Med	29b. Signature and title of certifier	end menner steted.		29c. Licens	se number	2	9d. Date signe	d (Month, E	Day, Year)
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	13	~	30. Name and address of person who c	AHMI MIN	0010	CI/IA	W St fin	nte 20.	·····		
ı	Sta	-	31. Date filed (Month, Day, Year) MAR 1 5 20	07 32 Registrer's S	Signature	easie	, , , , , ,	,,,,	7 200	- () .	21201
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		_	For Amend #10	g per St ri	988g P	3ry 39/1 9	9/07 pg Cer	men rtificat	t of H	ealth and N Death	Mental Hy	ygiene Reg. No.	2007	081	28
72			Decedent's Name (First, Middle)	fle, Last)							2. Date of D Month		Year	3. Time of D	Death
	Physicia /Medic		Marilyn Pearce								3/11/		Teal	12:50 a	a.m.
k.,	Examin		4a. Facility Name (If not institution	on, give street an	d number)			4b. City,	Town, or	Location of Death		4c.	County of Death		7-
AST .			Gilchrist Cente	r					vson				altimor		
	Funeral		5. Social Security Number	6. Sex	_	e (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B	lay, Year)	Cot	nplace (State or untry)	_
6	Director		213-67-5640 Usual Residence of Decedent	100		48	115.				10/28	/1958	Tor	onto, Ca	<u>anada</u>
	land	1	10a. State 10b. Count	у		10c. City,	Town or Lo	cation						10d. Inside City	Limits
	Mary -f she	ţō	MD Howar	ď		Elli	cott	City						1 □ Yes	XX No
	r 28a	Director	10e. Street and Number					10f. Zip	Code			10g. Citiz	zen of What Co	untry?	
	th with	a D E	3495 Spring Sho	wers Way	7				21043	3		US .	73	ada	
	ems ems	Funeral	11. Marital Status	12. Was		Ever in U.S.	. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Origin? (Sp in, Mexican, Puert	pecify Yes or No Rican, etc.)	lo-	 Race - Amer Black, White 		
9	or it	되	1 Never Married 2X Ma	If Ye	Yes 2⊠1 s,Give	Vo		1 ☐ Yes	2X No	Specify:			Specify: Whi	te	
21215-0036	hours tural"	d by	3 Widowed 4 Divorce	ent's Education	or Dates:		16a. Dece	dent's Usu	al Occupa	ation		16b. Kir	nd of Business/l	Industry	
1 5-	n 72 "nai	Set	(Specify only high	est grade comple		Ĩ	(Give life.	kind of wo	rk done d se retired	during most of wor	king	1		,	
12	withi iene. thar	Completed	Elementary/Secondary (0-12)	I	ege (1-4or 5 1		Homen	aker				Own	Home		
b	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle	e, Last)		•				18. Mother's Nan	ne (First, Middi	le, Maiden	Surname)		
<u>lar</u>	uld be Menta rked		Murry Esson							Helen (Corby				
Maryland	12 should be filed v and Mental Hygie is marked other t raumatic event, th	•	19a. Informant's Name/Relation	ship (Type. Prin	t)		19b. Mailir	ng Addres	(Street a	and Number or Ru	ıral Route Num	ber, City o	r Town, State, Z	?ip Code)	
≥.	1 and 2 Health tem 27 is	1	Mark Pearce/Hus	band		1001 71	8495	Spri	ng Sh	nowers Wa	bate Ell	icott	City,	MD 2104	3
Ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show of other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2XX remation	3 □Removal	from State	cei	ace of Dispo metery, cre	matory or	other plac	e)	Date	200. LO	cation - City or	rown, State	
Ë	t. Partmentant:		4 □ Donation 5 □ Other			Metar	o Creme		ad Addros	3/15			onsvill		-
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once.		21. Signature of Fundal Service	e Licensee						ss of Facility 1£man Fur					1
	20200		23a Part1 Enter the disease	or complications	that caused	the death	Do not en	250 Water the mo	ashir de of dvin	ngton Bly	or respiratory	kridg arrest.	e, MD 2	Approximate	-
			23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	st only one cause	-					3,	, , , , , , , , ,	,		Onset and D	eath
-	Physician /Medical		disease or condition resulting in death)	a	-	a conseque		NCE	5					10 year	255
	Examiner				Je to (or as	a conseque	erice or).								
E	52-	ē	Sequentially list conditions, if any, leading to immediate	b	ue to (or as	a conseque	ence of):								
	cd d ansit	Examine	that initiated events	C.											
ó	cate be executed physician and the burial-transit		resulting in death) Last	Di	ue to (or as	a conseque	ence of):								
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9	ertifica ing ple e as t	Mec	IF FEMALE:	00 - 15							-				
Вох	death certific e attending p id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 🗆	Live birth	pf pregnan 2 Fetal	death 3	⊒Ectopic p ⊒ Other (s		/		1	23d. Date of del Month	,	ear
P.0.	he de the a	Physician/Me	1 ☐ Yes 2 🖼 No 9 ☐ Unknown		Unknown	t time of de	aui 5	_ Outer (s	респу)						
	w requires that the death certific been signed by the attending p should be detached for use as		Part II. Other significant cond	itions contributin	g to death b	ut not resul	ting in the u	ınderlying	cause give	en in Part I.	23e. Dio	d tobacco u	use contribute to	the cause of de	eath?
Sp.	uires sign Id be	d by									1 [Yes 2	Öy€lo 3□ Pr	obably 4 □U	nknown
S	law req as beer 2 shou	Completed									24a. Wa		24b. Were au	ıtopsy findings a	ıvailable
Вe	е <u>т</u> е	ᇤ									au pe 1∐ Yes	topsy rformed? 2 2 No	death?	completion of ca 2∐ No	use of
ta	ician: Th	Be C	25. Was case referred to medi	cal						26. Place of Dea			1 100		
<u> </u>	Physician: this certific	To B	examiner? 1 ☐ Yes 250 No	Hospital	1 🗌 Inpatie	ent 2∏E	R/Outpatie	nt 3 🗆 D	OA Oth	er: 4 Nursing H	łome 5□Re	sidence	6 😘 6ther (Spe	city) hosp	ice
0 0	ng Ph fter th neral		27. Manner of Death 174 Natural 5 ☐ Pend		Date of Inju	ury ny Year)	28b. Time o Injury	of	28c. Injur Wor	y at k?	28d. Describ	e how injur	ry occurred		
Sio	endir eath. or: Al	atic	2 ☐ Accident inve	stigation				M		Yes 2 ☐ No					
Division or Vital Records,	or Att ter de pirect n by t	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	rmined 28e.	Place of inj building, et	jury - At hon tc. <i>(Sp</i> ec <i>ify)</i>	ne, farm, st)	reet, facto	ry, office			(Street an Town, State		ural Route Numl	ber,
	pital ours af		29a. Certifier 1 Certif	ing Physician:	To the heet	of my knou	vlodao des	th occurre	d at the ti	me, date and plac	e and due to th	he cause(s) and manner as	s stated	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Medical	(Check only 2 Medic	al Examiner: Or	the basis of manner st	of examinati	ion and/or in	nvestigatio	n, in my c	opinion, death occ	urred at the tim	ne, date and	d place, and du	e to the cause(s))
	o the	Me	29b. Signature and title of certi		7			25	c. Licens	se number		29d. Da	te signed (Mont	th, Day, Year)	
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	01		30. Name and address of pers	on who complete	d cause of o	death (Item								,200	
	1		Helen M. E	iordan				rails	SS	st Balt	more,	and	212	04	
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ORIGINAL

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Shaun	M.	Perry	

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Shaun M. Perry		1- For State Registrar	St	ate of	Marylan		artment ertificate		ealth and eath	Menta	al Hyg		Reg. No.	21	10,000	7 0812
Physicia Medical Examir	n/	1. Decedent's Name			7							Date of De Month	Day	Year		3. Time of Death 1146 hrs
Theureal Examin		Shaun Mi 4a. Facility Name (i			r	per)		4b. C	ty, Town, or L	ocation of		March 9,		County of	Death	11101110
		19 Bratton F			-				ton				Ce			
Funeral Director		5. Social Security N	259	6. Sex		Age (In yrs.	last birthday)		Under 1 Year onths Days	If Under Hours	Min.		7, 19		Cou	iplace (State or Foreign ntry) .orado
any	-	Usual Residence of 10a. State	Decedent 10b. County			10c. City	y, Town or Loc	cation			-					10d. Inside City Limits
* .	ь	MD	Ceci1			E1k	ton									1 Yes 2 X No
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (Dean Lews)			•				18		•		, Maiden S	,		
212 ould be Menta marke	To Be	19a. Informant's Na	me/Relations	hip (Type			19b. Mai	iling Add	ress (Street				ierke umber, City		State,	Zip Code)
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Baltimore, permit. Pages I as Department of Hee Important: If ite	-	4 Donation 5	Other Spraine	pecify:		Me			ory, I		3/13,			timo		MD
Ba perm Depa Impa injur		21. Signature of Fu	1.12	Cerisee	C. Too	dd Dri	ng [t	rema	and Address of Ation S Frederi	ocie	ty of	f Mary	yland	Inc	228	
Physician		23a. Part I. Enter th				sed the deat	h. Do not ente	er the mo	ode of dying, s	uch as ca	rdiac or re	espiratory a	rrest, shoc	k, or hear	t	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (or condition resulting			ethadone										- 8	Death
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Divi	Certification:	3 Suicide 4 Homicide		d not be rmined	(Specify)		in dwe			marrig, cto		or Town				
/ / 10 0		29a. Certifier 1	Certifying P	hysician:	To the best of	of my knowle	dge, death oc	ccurred a	at the time, dat	e and plac	ce, and du	e to the ca	use(s) and	manner a	s state	d.
To the comple	Medical		1	an	the basis of manner star	examination ted.	and/or investi	igation, i	n my opinion, 29c. License		urred at th	ne time, dai				th, Day, Year)
	=	29b. Signature and	gae of certifie						O.C.N					h 10, 20		ur, Day, reary
7	-	30. Name and addr	ess of person	who som	pleted cause	of death (Ite	m 23a)	-								
0		Mary G. Rip	ple MD.		y Chief Me	edical Exa	aminer 1	111 P€	enn Street,	Baltimo	ore, MD	21201				
Sta Regist		31. Date filed (Mont	h, Day, Year)	2007	32 degi	strar's Signa	ture	d	9							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 10e per 1h 2865 3-19-07 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 00 am **Physician** Mamie D. Prouty /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square
5. Social Security Number 6. Se timore M 05e da le Hospital Center If Under 24 Hrs. 8. Date of Birth December 5, 1910 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Days Mary Tand **Funeral** Hours 1 □ M 2 XF 96 Months 215-07-0755 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County or 28a-f show ?? is marked other than "natural", or Items 23s or 28s-f shov traumatic event, the Medical Examiner must be notified at 1 ∑Yes 2 ☐ No N/A Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Stree Dan Mire Is USA 21234 7610 Daniela Avenue Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Efementary/Secondary (0-12) Coflege (1-4or 5+) Clothing Seamstress 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Salvatore Mugavero Gregorio Mugavero 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and t 19a. Informant's Name/Relationship (Type, Print) 9206 Sandra Park Road Perry Hall Maryland 21128 Department of Health a important: If item 27 is sny injury or other traisons. Greg Prouty/Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 3/17/07 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and dr s of Facility Lechard J. Ruck, Inc 5305 Harford Road B 21. Signature of Funeral Service Licensee Kelton Baltimore Maryland 21214 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. tmmediate Cause (Final week cranial bleed Physician -ntra disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months?

1 Yes 2 ANo
9 Unknown 4☐Pregnant at time of death 5 Other (specify) signed by the all d be detached for P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown should should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Seizures 2/X No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one) director Hospitaf: 1 * Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Certification: 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: A 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 - Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and, address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive Baltimore, Hd 21237

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State

Registrar

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** BPhillip 7 :60 pagm narch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year ge (In yrs. last bir 1 timore Obblestone Court 5. Social Security Number

216 40 .232

Usual Residence of Decedent 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) yrs. last birthday) **Funeral** Days Min. 1 □ M 2 💢 F Director death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show at r 28a-f sh notified Yes 2 No altimare Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or 12. Was Decedent Ever in U.S Armed Forces? 'abblestone Funeral Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items, any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 211 No Specify: Black Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Keeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Pages 1 and 2 should be Sarah Phillips Black Siah 19a. Informant's Name/Relationshic (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200. Place of Disposition (Name of cemetery, crematory or other place) hoad Baltimere, mD 21204
Date 20c. Location - City or Town, State ocqueine Wallace doughter Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ark 03/7:2007 Baltimore MD 22. Name and Address of Facility Vougna C. Greane Junua Serne 4 Donation 5 Dother (Specify) permit. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iberty hour handallotaur mn 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTMOULA MURTH MVA **Physician** /Medical Due to (or as a consequence of): **Examiner** 0W66371VE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) MOLOMYOF ig physician and as the burial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy ţ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) ate has been signed by the page 2 should be detached. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ityph Thus ion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown OMStors MULTUS 24a. Was an autopsy performed? 1☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 ☐ Nursing Home Medical Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Many er of Death 1 V Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No death. neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i To the Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and the of cortifier 29d. Date signed (Month, Day, Year) MD 20046502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 535 BANSTEIN 1838 THE Aronow mul MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

MAR 1 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Mary Katherine Rutsky March 14, 2007 1615 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** n/a 119 East Cross Street Baltimore 7. Age (In yrs. last birthday) 91 vrs | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | March 21, 5. Social Security Number 175–01–2693 6. Sex 9. Birthplace (State or Foreign · 1915 **Funeral** Months 1 □ M 2XX IL Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Charleroi PA Washington 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5th Street 15022 IISA 922 Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hyglene. Important: If Ifem 27 is marked other than "natural" or incorporation of the property or other traumatic events. Race - American Indian. Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes **②CX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes **2CX**No White Specify: ģ 3€Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sima **Blasko** Mary Joseph 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 East cross Street, Baltimore, MD 21230 19a. Informant's Name/Relationship (Type. Print) Son Richard Rutsky Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Sacred Heart Cemetery 03/19/2007 Carroll Township, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ² Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 ano 23a. Part1. Enter the disease, or complications that car shock, or heart failure. List only one cause an each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BY MEDICAL /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 mor Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Linknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 Unknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a. Was an hask autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: appletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury f (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After 1 Natural
2 Accident 5 ☐ Pending investigation Subjectell 1 ☐ Yes 2 🗖 No Novemberedo Unknown 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Street PA determined 4 Homicide 1 Conflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) m 23a) (Type, Print) 30. Name and address of person who completed gause of death (It

State

Registrar

31. Date filed (Month, Day,

Year)

5 2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla		artment of F		id Mental H	lygiene Reg. No.	9 7	08133
	×		Registrar 1. Decedent's Name (First, Middle	e, Last)			Timouto or	Doutin	2. Date of			3. Time of Death
Н	Physici	_		n Ryan					Month	Day 12 20	Year 007	9:40 A M
1	/Medic		4a. Facility Name (If not institution		number)		4b. City, Town, o	r Location of D		4c. County		3.10 11
Jes.	LAUTHI	3	2915 Tapered La	₃ne			Bow	ie		Prin	ice (George's
	Funeral		5. Social Security Number	6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of Month,	Rieth		place (State or Foreign
	Director		041-28-5362	1 X M 2 □ F	69	Yrs.	Months Days	Tiouis	March	Day, Year) 24,1937	New	York
	pui "		Usual Residence of Decedent 10a. State 10b. County		100	City, Town or Lo	cation					10d. Inside City Limits
	short short	'n	,			•						1 Tves 2 No
	the N 28a-f lotifi	Director	MD Prince	e George'	S	BC	Wie 10f. Zip Code			10g. Citizen of W	What Cour	**
	with with			ſ ano				715		USA		nuy:
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at	Funeral	2915 Tapered 1		ecedent Ever in	U.S. 13. V			? (Specify Yes or			can Indian,
	fter d	Fun	1 □ Never Married 2 🕅 Marr	Armed	Forces? s 2 ☐ No Give			an, Mexican, P	? (Specify Yes or Puerto Rican, etc.)	Black	k, White,	
99	urs a al", o Exam	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, (Year or	Give Dates: 1959	9-62	1∐Yes 2M∏No	Specify:		Specify	Whi	.te
5-0036	72 ho	ted	15. Deceden (Specify only highe	t's Education	d)	16a. Deced	dent's Usual Occup	ation	fwarking	16b. Kind of Bu	siness/In	dustry
2	thin 7	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life. I	DO NOT use retire	d)	working			
2	filed within 72 Hygiene. hther than "nai hther the Medie	Completed		54	<u> </u>	Sys	stems Ana			U.S.		· · •
nd	d d al	Be	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Midd	lle, Maiden Surnam	e)	
Maryland 2121	should be filed vand Mental Hygies marked other tumatic event, th	은	Thomas A. Ryan			1			E. Ward			
Jar	a so		19a. Informant's Name/Relations							nber, City or Town,		Code)
	is 1 and 2 of Health Item 27 i		Nancy A. Ryan 20a. Method of Disposition	/ spouse	20h		Tapered		Bowie,	MD. 20 20c. Location -)715	Our State
وّر	Pages nent of i int; If Ite		1 X Burial 2 ☐ Cremation		m State		sition (Name of matory or other pla	1			•	JWII, State
altimore,	iit. Partme		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Sa		eart Ceme Name and Addre			Bowie,		
Ba	permit. Pages 'Department of H Important: If Ite any injury or of		P P 2	Liou iso	01		512 NW C			unerál Ho vie, MD.	ome 2071	5
	de alto		23a. Part1. Enter the disease, or	complications tha	t caused the de				-		2071	Approximate
	Physician	2 /4	shock, or heart failure. List Immediate Cause (Final	only one cause or			10.	100			7	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due t	to (or as a vins	equency of):	Can					Sycars
1	Examiner			h .		3						
N.	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	to (or as a cons	equence of):						
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с								
30,	oe execian a	Ě	resulting in death) Last	Due t	o (or as a cons	equence of):						
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d						····		
y X	leath certific attending p	Physician/Me	IF FEMALE:	23c If yes (outcome pf preg	nancy				201 2		
Box	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 DLive	e birth 2 Fe	etal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Mor	e of delive	ery Day Year
o.	w requires that the de been signed by the should be detached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9☐Unl		deall JL	Tottler (specify)					
_	that led by deta		Part II. Other significant condition	ons contributing to	death but not r	esulting in the ur	nderlying cause giv	en in Part I.	23e. Di	d tobacco use contr	ibute to t	he cause of death?
Records,	quires n sigr ald be	d by							_ 1	Yes 2□ No	3 Prot	oably 4 Unknown
000	w rec	Completed							24a. W	as an 24b. V	Vere auto	ppsy findings available
	The lav	E O							pe	topsy p	rior to co leath?	mpletion of cause of
Vital	ilcian: Th certificate ector, pag	Be C	25. Was case referred to medica	1			· · · · · · · · · · · · · · · · · · ·	26. Place of	1 Yes Death (Check onl	T	□Yes	21 No
>	yslci is cer direc	0	examiner? 1 ☐ Yes 2 No	Hospital: 1 [☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	OF:	1.0	esidence 6 🗆 Othe	er (Specit	fv)
0	ng Ph fter th neral	T:uc	27. Manner of Death 1 Natural 5 □ Pendin	/8.4	te of Injury onth, Day Year)	28b. Time of Injury	28c. Injur Wor			e how injury occurre		
200	eath. or: A he fu	ätic	2 ☐ Accident investi	gation				Yes 2 □ No				
Division or	ter de	Certification:	3 ☐ Suicide 6 ☐ Could determ	inod 200. Fla	ce of injury - At ilding, etc. (Spe	home, farm, stre cify)	eet, factory, office		28f. Location City or 7	(Street and Number Fown, State)	er or Rura	al Route Number,
	urs al urs al eral D		29a. Certifier Certifyir	District Total	h. h				- K.			
	Hos 24 ho Fun etely 1	Medical		Examiner: On the	ne best of my k basis of exami anner stated.	ination and/or in	vestigation, in my	me, date and p ppinion, death o	occurred at the tim	ne cause(s) and ma ne, date and place, a	nner as s and due t	o the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifies completely filled in by the funeral director;	Me	29b. Signature and title of certifie		stated.		29c. Licens	e number		29d. Date signed	Month,	Day, Year)
	⊢ s ⊢ ő 		* Kanen	wer			052	2830		March		* '
0	3 4	1	30. Name and address of person		use of death (It	em 23a) (Tvpe.	Print), _					,
_	10		Tegnine We	Vne/1901	BISKA	ate Moso	1#300	Anno	polis,	MO 2	140,	/
Ø	Sta		31. Date filed (Month, Day, Year)		. Registrar's Sig							
	Registr	ar	MAR 1	5 2007	Pagasa	JE A	23466					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9865 3-23-07 vt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 200

			- Hogistiai	cate of Dea	ith	Reg	ene . No. 200	7 0813
	Physicia		1. Decedent's Name (First, Middle, Last) Melissa Blake Rowny Melissa Blake Rowny	y		Date of Death Month arch 1	Day Year 1, 2007	3. Time of Death 11:25 P ^M
	/Medic Examin	al		City, Town, or Locat		al CII	4c. County of Death	
				Chevy Chas			Montgome	
7	Funeral Director		215-54-4730 1□M 2⊠F 58 Yrs. Moi	Jnder 1 Year If Ur nths Days Hou	urs Min.	Date of Birth (Month, Day, Yay 26,	ear) Cou	nplace (State or Foreign untry) 10
	and w t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n				10d. Inside City Limits
	with the Marylan a or 28a-f show t be notified at	tor	Maryland Montgomery	Chevy Cha	se			1 ☐ Yes 2 👿 No
	th the or 28a e noti	Director	10e. Street and Number 10	of. Zip Code		10g	. Citizen of What Co	untry?
	ath wi	ral	5329 Woodlawn Avenue	2081			United S	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 🖾 Married 1 □ Yes 2 🖾 No	Decedent of Hispanions, specify Cuban, Me Yes 2⊠ No Spe		y Yes or No- an, etc.)	14. Race - Amer Black, White Specify:	
ς C	72 hc "natu	etec	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind	Usual Occupation of work done during OT use retired)	most of working	16	6b. Kind of Business/I	ndustry
121	within ene. than '	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	o <i>r use retired)</i> maker			Own Hom	e
7 0	filed Hygid Sther ent, th		17. Father's Name (First, Middle, Last)		Mother's Name (F	irst, Middle, Ma	iden Surname)	
<u> a</u>	should be nd Mental marked matic ev	To Be	William T. Blake		Dorot	hy L. S	Swisher	
ary	C1 60 .00 10	-					City or Town, State, Z	
	s 1 and s f Health item 27 other tr				enue, Ch		oc. Location - City or	
Baltimore,	permit. Pages 'Department of HIMPORTMENT: If ite any injury or of once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematori	rý or other place) ▼	March 2007	7 4,	Bethesda,	Maryland
n	Dep Impo any once		M01433 Beth	esda-Chev esda, Mar	y Chase	Inc. 75	57 Wiscon	neral Home/ sin Avenue
ì	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Breast Cancer resulting in death)				t,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):					
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):					
	xecute and ul-trans	Examiner	Cause (Disease or influir) that initiated events resulting in death) Last Due to (or as a consequence of):					
68/60,	ificate be executed g physician and as the burial-transit	edical E	d					
	= 0,0	Medi	IF FEMALE:					
.O. Box	requires that the death certi een signed by the attending hould be detached for use a	Physician/M	23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome pr pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ecto	opic pregnancy er (specify)			23d. Date of deli Month	very Day Year
7	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause given in F	Part I.		cco use contribute to 2⊠ No 3 ☐ Pro	the cause of death? obably 4 □Unknown
II Kecords,	The law ate has b	Completed				24a. Was an autopsy pertorme	ed? I death?	topsy findings available completion of cause of 2 \square No
Vital	ician: Sertific ector,	Be	25. Was case referred to medical examiner? Hospital:		Place of Death (C			
	Attending Physician: r death. ector: After this certific by the funeral director,	<u>1</u>	1 ☐ Yes 2 ☑ No	DOA Other. 4[ce 6 Other (Spec	eify)
0	th. : After : funer	tjon	1 ⊠ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	28c. Injury at Work? 1 ☐ Yes	1	. 50001150 11011	injury occurred	
DIVISION OF	1 to 1 to 1	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fi building, etc. (Specify)	actory, office	28f.	Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	the Hospital or in 24 hours afte the Funeral Dir npletely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occ and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.					
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	29c. License num	ber	290	d. Date signed (Month	ı, Day, Year)
	5			D00332	.43		March 12,	2007
J	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, M.D. 5454 Wisconsi	n Avenue,	#1300,	Chevy (Chase, Mar	yland 20815
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 5 2007	9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decement's Name (First, Middle, Last, Day Month Year **Physician** 2007 15,40 MARCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1timore SAMARI HOSPI 6001 TAN 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex M 2□ F **Funeral** Months Davs Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County If item 27 is marked other then "natural", or itema 23s or 28s-1 show or other traumstic event, the Madical Examinat must be notified at 1 Yes 2 □ No Director saltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number naton Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12 Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 11. Marital Status 2 Marned 1 Never Married 1 ☐ Yes 2 📉 No Yes, Give 'ear or Dates: Specify Blac Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na eny Injury or other traumatic event, the Madia 2006. (Specify only highest grade completed) College (1-4or 5+) econdary (0-12) ormer 18. Mother's Name (First, Middle Maiden Surname) Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rurate 19a. Informant's Name/Relationship (Txp MD 625 N baltimore Owngs Mills, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 F

4 Donation 5 Other (Specify) Date 3 Removal from State 21. Signature of Funeral Service Licenses STOF FRENCH rece Approximate Interval Between Onset and Death 23a. Part1. Enter(the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPTICEMIA **Physician** /Medical Due to (or as a consequence of): Examiner ANCYTOPENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit NON HOD GRINS Division of Vital Records, P.O. Box 68760, 5 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Tunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed 2. No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 ANatural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RESOOO MARCH 14 2007

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOODSHHARITAN 1405PITAL HANTA WASSEN 5601LOCHRAVEN BLVD BALTIHORE NA 24239

3 Registrar's Signature

103

2007

Malakyah V Sirleaf Physician/ Medical Examiner Funeral Director any 28a-f show or items 23a or 28a-f sho must be notified at once. Director more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with tent of Health and Mental Hygiene. Funeral or items traumatic event, the Medical Examiner marked other than "natural". \$ Completed æ If item 27 is ment 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death V. SIRLEAF 2339 hrs MALAKYAH March 11, 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Sinai Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Feb. 2, 1987 082-78-2137 20 Country) N.Y. M 2XF Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 No Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe 2819 Gatehouse Drive 21207 United States 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married 2X No Yes Black Yes 2 X No specify: Specify: Widowed Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Disabled Disability 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elouise Richardson Momolu Sirleaf, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Momolu Sirleaf, Sr./Father 2819 Gatehouse Drive Baltimore, Md. 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3-24-07 Gate of Heaven Cem. Silver Spring, Md. mportant Denation 5 Other Specify 22. Name and Address of Facility ture of Funeral Service Libensee Capitol ve., NE Mortuary Inc. 20002 ЪĊ 1425 Maryland Ave., Wash., 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a Complications of Rett syndrome Immediate Cause (Final disease) xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death Pregnant at time of Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 V No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? certificate Yes 2 V N director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ 21 DOA Nursing Home 5 Residence 6 Inpatient FR/Outpatient 3 this 1 Yes After 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural Yes 2 death. Pending within 24 hours after death To the Funeral Director: filled in by the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 12, 2007 O.C.M.E.

Registrar

State

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death

		Please	Type or Prin	nt in Bl	lack In	delible Ink.	Ensure A	II Copies	Are	Legible.		
		For	State of Ma	aryland		artment of H		/lental Hy	giene	200	7 08137	
		1 - State Registrar			Cei	rtificate of	Death		Reg. No).		
Physicia	an	Decedent's Name (First, Middle, Last)				4 Test (10 Jest	01	2. Date of De Month	Da		3. Time of Death	
/Medic	al -	Lester Alexander Sabo a.k.a. Leste 4a. Facility Name (If not institution, give street and number) Rockville Nursing Home				4b. City, Town, o	March .		2007 County of Dea	3:35 P. M		
Examin	er					Rockvil			1	ntgomer		
Funeral				e (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Bir	thplace (State or Foreign	
Director		135-09-9122 96 Yrs. Jun									ngary	
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
naryla f sho	o	New Jersey Middlesex Carteret									1 X Yes 2 No	
the 28a-	Directo	10e. Street and Number	3X	Cart	10f. Zip Code					lizen of What C	ountry?	
h with		167 Randolph Stre	et			07008		Uni	ted Sta	tes		
deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No	0-	14. Race - Ame Black, Whi		
or its		1 Never Married 2 Married	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			1 ☐ Yes 2 ☑ No	Specify:					
hours tural	ed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's E	16a Dece	dent's Usual Occup	ation	16b K	Specify: White					
in 72 n "na fedic	plete	(Specify only highest g	rade completed)		(Give	kind of work done DO NOT use retired	during most of work	ding	100.1	and or business	middatty	
d with giene or tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5	0+)	Post	Master			U.:	S. Posta	al Service	
al Hy l othe vent,	Be	17. Father's Name (First, Middle, Las	<i>t</i>)				18. Mother's Nam	e (First, Middle	e, Maiden Surname)			
ould b Ment arkec atic e	To.	Alexander Szabo					Sophie R					
l 2 sh and is m raum		19a. Informant's Name/Relationship Barbara S. Hilber				ng Address <i>(Street</i> Acacia A					* '	
1 and Health		20a. Method of Disposition	g / Daugne							ocation - City or		
remit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland reputnent of Health and Mental Hygiene. In portant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 MBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Hung	metery ciel	osition (Name of matory or other place metery	Marc 2007			•	ew Jersey	
ortan		21. Signature of Funeral Service Lice	**	Mero							Chase, Inc.	
any any		1 75.(3		M0089		57 Wiscon						
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✓ /Medical Examiner		resulting in death)	Due to (or as									
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F 3 F 8		1 Travela	talish	al.	,0	TO	01978	5			1th, 2007	
15		30. Name and address of person who	completed cause of	leath (Item 2	23a) (Type,		- , , , ,	-				
7		Frauke Westphal,	M.D., 120	1 Seve	en Loc	hs Road,	Rockvill	e, Mary	lanc	1 20854		
Sta		31. Date filed (Month, Day, Year)	3 Registr	ar's Signatu	re And	and a						
Registr	ar	WAKIS	001									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 11, March 10:55 A M Pete Sotiropoulos /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April I, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 381-34-3422 1X M 2 F 72 Director Greece Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits . Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 1 X Yes 2 No Director Ontario Woodbridge None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 70 Sandys Drive L4L-3E3 United States is 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Automobile 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ioannis Sotiropoulos Katingo Christopoulos ည or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Vranis / Daughter 9220 Marseille Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 March 16 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State Elgin Mills Cemetery 2007 Toronto, Canada 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. Ungelette M01305 100 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** yo cardio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 dnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 NA funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 2 R/Outpatient 1 🔲 Inpatient 3□ DOA Medical Certification: To this e Hospital or Attending Ph 24 hours after death. e Funeral Director: After th letely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Sunil Saxena, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 15 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 – For State Registrar		Maryland		artment of I		and Mental F	Reg. N	2007	3. Time of Death	
	hysicia /Medic	aĺ	Doris Saylor Sau As Facility Name (If not institution, g	1	abort.		4b. City. Town,	or Location o	Month March	9, 2	Year 007	11:00 A ^M	
Fı	xamin ineral	er	Future Care Ches 5. Social Security Number 6	apeake	7. Age (In yrs. I	ast birthday) Yrs.	- 1	rnold If Under 2 Hours	24 Hrs. 8. Date of (Month,	An Birth Day, Year	nne Arun		
D	Modes 1	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								1710 1141	10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
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within 72 hours after death with the Maryland ene.	el, or items?	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For	2 ∰ No e		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No		gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Ame Black, Whi		
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Maryiand A Nd 2 should be filed Ith and Mental Hygi	arked other atic event, I	To Be Co	17. Father's Name (First, Middle, La Horace Dodge Rou	17. Father's Name (First, Middle, Last) Horace Dodge Rouzer						er Mu			
Deficiency, ING.	Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Extensinat must be notified at once.		Janice S. Pusey 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Special Signature) of Funeral Service Lie	/ Daughter 301 Daughter 20b. Place of Discomptions 20b. Place of Di			Belair Desition (Name of matory or other place of the policy of the place of the policy of the polic	rive,	Bowie, March 13, 2007 Kobert A Chase, Inc	Be Pum	c. Location · City or Town, State Bethesda, Maryland mphrey Funeral Home 7557 Wisconsin Aver		
Physical Phy	ysician end mineral-transit te burial-transit	Ical Examiner	23a. Part f. Enter the diseas, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (M014 aused the death ach line. Zhou or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or	uence of):	ter the mode of dy	ng, such as	and 20814- cardiac or respirator			Approximate Interval Between Onset and Death	
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F E		þ	Part II. Other significant condition			tobacco use contribute to the cause of death? Yes 2 12 No 3 Probably 4 Unknown							
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ar is	To the Funeral Directormpletaly filled in by	ledical	(Check only 2 Medical E.	kaminer: On the ba	best of my kno asis of examina her stated.	wledge, dea tion and/or in	nvestigation, in my	opinion, dea	nd place, and due to oth occurred at the ti	me, date a	nd place, and du	e to the cause(s)	
To	Con	2	29b. Signature and title of certifier	11		M	△ 29c. Licer	50	725		Date signed (Mor		
5	Sta Registr		30. Name and addr s of per o w L 31. Date filed (Month, Day, Year)	dingo	e of death (Iten	110	P int)	Hwy	M.ller	54.6	le M.	2007 1) 2/108	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#106, 19baperFH of Realth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month BERNICE /Medical SIEGEL MARCH 2007 12:50P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTWOOD NURSING HOME LUTHERVILLE BALTIMORE 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ F Director 217-26-9373 76 06/09/1930 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits notifled Director 1 ☐ Yes 2 ☐ No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code or be Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Items 23a cliner must be 6521 GARDENWICK ROAD 21209 by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify WHITE 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER GREETING CARDS & GIFTS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked c ABRAHAM BERLIN GERTRUDE ပ္ MILLSTONE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gardenvick GARENWICK ROAD Item 27 i BALTIMORE, MD 21209
Date 20c. Location - City or Town, State SANDER A. SIEGEL / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of I
Important: If Ite
any injury or of 1 Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) BETH TFILOH CONG. 03/13/2007 WOODLAWN, MD Signature SOL LEVINSON & BROS., INC. remin 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOMYOPATHY, END STAGE MONTHLY /Medical Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 💢 No 3 ☐ Ectopic pregnancy Month Day Year ed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by AORTIC STENOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2X No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 💢 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) ပ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 Tes al or Attend s after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25643 03/12/2007

State Registrar 31. Date filed (Month, Day, Year) MAR 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Siesel Gladys Baltimore, Maryland 21215-0036 GARS KRIZE

P.O. I

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 20b per th 9865 3-13-07 vt
State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yeer 12:24 GLADYS March SIEGEL 11 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospitarol Barthmare Baltimore City N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖵 F Director 217-05-9689 87 04/22/1919 MD Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, it a Madical Examinar must be redified at MD BALTIMORE REISTERSTOWN Director 1 ☐ Yes 2 👿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14214 HANOVER PIKE by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X**☐ No Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H SAMUEL WOLKOVSKY LINA 2 FRANKLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ar Important: If item 27 Is any injury or other trau LANA BARRICK / DAUGHTER 14214 HANOVER PIKE - REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of 03 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation, 5 □ Other (Specify) HEBREW YOUNG MENS 11/13/2007 WOODLAWN, MD 21. Signatu e Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respliching Priysician tillfulc 10 /Medical Due to (or as a consequence of). Examiner Inkac 1 ania Almillhaid Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine US. The law requires that the death certificate be executed use as the burial-transit elkenos c that initiated events resulting in death) Last Due o (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No the 9□ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl. one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Impatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely 1 (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) RES- CCC March, 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Acophal of Ballmore n.o Sina 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAR 1 5 2007

Physician /Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. : If Item 27 Is marked other than "natural"; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

To Be Completed by Funeral Director

	Please	Type or P	rint in E	3lack	Ind	elible	lnk.	Ens	ure A	II Copies	s Are	e Leg	ible.		
For State Registrar		State of	Marylan					lealth Death		1ental Hy	/gier Reg. 1	1	007	0814	
1. Decedent's Nam	1. Decedent's Name (First, Middle, Last)					2. Date of Dea						3. Time of Death			
ARLYN	E C. SCHM	ALBACH				MARCH 10			10	, 20	o7	7:45 P.M			
4a. Facility Name (If not institution, giv	e street and numb	per)		4	4b. City, 1	Town, o	Location	of Death		4	tc. Count	ty of Death		
CARROLL	LUTHERAN	VILLAGE			1	WESTI	MINS	STER				C	ARROL	L	
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					""//						place (State or Foreign				
215-56-6	0307	1□M 2 X)F	90	Yr	s.			1.00.0	1	6/6/19	16			LAND	
Usual Residence of	10b. County		10c Cit	ty, Town o	or Loop	ation								10d. Inside City Limits	
Toa. State	Tob. County		100.010											1 ☐ Yes 2\1 No	
MD	CARROLI	<u> </u>		WEST	CMI	NSTEF									
10e. Street and Nu		!/				10f. Zip					10g. (Citizen of What Country?			
300 ST.	LUKE CIR							158				USA	4		
11. Marital Status		12. Was Deced	eş?	.S.	13. Wa	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian, Black, White, etc.				
1 □ Never Mar 3 Widowed	ried 2 Married 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			4 TV 0 TV						Specify: WHITE				
(Sne	15. Decedent's E	ducation ade completed)		16a. D	ecedei	nt's Usua	l Occup	ation	st of work	ina	16b. Kind of Business/Industry				
Elementary/Sec 12 GRADE	ondary (0-12)	College (1-4	lor 5+)	1	(Give kind of work done during most of working life. DO NOT use retired) TEACHER'S AIDE EDUCAT					TION					
17. Father's Name	(First, Middle, Last	")						18. Moth	er's Name	e (First, Middle	, Maid	en Surna	ime)		
HARRY (CHENOWETH						İ	ΕI	LEANC	OR BRAU	ER				
19a. Informant's N	lame/Relationship (Type. Print)		19b. N	/lailing	Address	(Street	and Numb	er or Rur	al Route Numb	ber, City	y or Town	n, State, Zip	Code)	
DR. WILL	MER L. JOI	NES/SON-:	in-law	10	8C	EDGEF	RTON	ROAL	O TO	OWSON,	MD	2128	86		
20a. Method of Dis		,	20b. F	Place of D cemetery,	Disposit	tion (Nam	ne of			Date		Location	- City or To	own, State	
	☐ Cremation 3 ☐ 5 ☐ Other (Special		ate i	RAINE	E PA	ARK C	CEM.			+/2007			WN, M		
21. Signature of F	uneral Service Lice	nsee Hays	1		22. N 852	Name and	d Addres	ss of Facil	ity THE	JOHNS	ON I	FUNEI	RAL HO	OME, P.A. 286	
23a, ant. Enter	the disease, or com art failure. List only	cations that cau	sed the deat	h. Do not	t enter	the mode	of dyin	g, such as	s cardiac	or respiratory a	arrest,		No.	Approximate	
Immediate Cause disease or condition resulting in death)	(Final	a. Chr.	as a conseq	0	tu	tu	uci	tern	èsi	ulma	ser	zd	401	Approximate Interval Between Deet and Death	
Sequentially list or if any, leading to in cause. Enter Under that initiated events	onditions, mmediate erlying	b	as a conseq								U	6			
resulting in death)	Last	Due to (or	as a conseq	uence of)	:										

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

xaminer To the Hospital or Attending Physician; The law requires that the death certificate be executed

physician and s the burial-transit attending pl within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Division or Vital Records, P.O. Box 68760,

- 1	ш
	/Medical
	Physician
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Medical Certification

State Registrar

29a. Certifier (Check only one)

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F FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

23c.	If yes, outcome pf pregnanc
	1 Live birth 2 Fetal de
	A Pregnant at time of deat

eath 9☐Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery Month Day

1 ☐ Yes 2 ☐ No

Year

Unknown

art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

110men	ded a
Atrical	Pilis Matinia
11 Noun	per una car-
Was case referred to medical	

24a. Was an autopsy perform Yes 2 Yes Place of Death (Check only

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

3 Probably

examiner? Hospital: Other: 2 ER/Outpatient 3□ DOA 1 Inpatient Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death Natural 2 Accident 28c. Injury at Work? 5 ☐ Pending investigation

28d. Describe how injury occurred M 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature

death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** ,2007 March harnton bert /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Baltimore 15ta Social Security Number 6. Sex OL Home 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 ☐ F 8.3 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exa<u>miner must be notified at</u> 1 ☐ Yes 2 No Director altimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15A Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 1 4 Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) 15 ench Operator Hrmco Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Holland Patrice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health : 21207 5533 Belle Ave Baltimore mo ena Incrnten injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Garrison Forest n Forest 3.21.2007 Quings mills mb 22. Name and Address of Facility Voughn C. Green Juneval Service 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Road Prandallstown MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trans Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical attending pate for use as t 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown certificate has been si rector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1∐ Yes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) Wiff C Hospital: 2**7** No 2 ER/Outpatient 3 DOA 1 🔲 Yes 1 🔲 Inpatient Certification: To Division or this 27. Manner of Death

1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation n 24 hours are, the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Charles ST Bon 10 6201

State Registrar 31. Date filed (Month, Day, Year)

MAR 15

2007

DHMH 17 Rev 1/2001

Registrar's Signature

7-01932	Please Type or Print in Black Inde			
Angie L. Thomas	State of Maryland / Departm		ygiene 200°	7 0014
	Registrar	cate of Death	Reg. No 2. Date of Death	2 Time of Death
Physician Medical Examine		NTO C	Month Day Year March 11, 2007	3 Time of Death 2053 hrs
noulour Examina	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		
	Sinai Hospital	Baltimore	NA	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bi			thplace (State or
Director	212-102549/ 1 M 2 FF 52	Yrs. Months Days Hours Min.	TilV 31, 1954 Co	untry)
	Usual Residence of Decedent		V4.9 // // /	
wany	10a. State 10b. County 10c. City, Tow	n or Location		10d Inside City Limits 1 Yes 2 No
1aryland 28a-f show Latonce,	11/1 10/14	ALIMON	[10 0V 10 10 10 10 10 10 10 10 10 10 10 10 10	
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cour	ntry?
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland of other than "natural", or items 23a or 28a-fah. It, the Medical Examiner myst be notified at once	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	Marifu Vos or No. 14 Race - Ameri	can Indian, Black,
sath w items	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		tall fildian, black,
her de		1 Yes 2 No specify:	Specify:	ACK
atural"	15. Decedent's Education (Specify only highest grade completed) 16a	. Decedent's Usual Occupation (Give kind of v		ndustry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti	//nTA/	11/-
vithin ene.	12-14	TEAM MESS	CHOMM	
215-0036 be filed within 7 ntal Hygiene. Red other than ent, the Medical		18.Mother's Name	(First, Middle, Maiden Surname)	
O 3 8 3 8 0	19a. Informant's Name/Relationship (Tyge, Print)	9b. Mailing Address (Street and Number or F	Pural Poute Number City or Town State	Zin Code) AQ 1177
MD 21 d 2 should th and Mer n 27 is mar turnatic ev	MICHAEL NILL-BrothER	17 GIERRA GRALE	Anti C Duning Mil	la mo
	20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery,	Date 20c. Location - City or	Town, State
nore ages lant of Hore	Bullar 2 Cremation 3 Removal Iloni State	atory or other place)	15-017 (n 100 161/1)	1/5 MD
Baltimore, permit Pages I ai Department of He Important: If ite	4 Donation 5 Other Specify: 21. Signatu Funeral ervic Licens	22. Name and Address of Facility	707050M1 11/10	3 21224
	Knoth 11 mgs	GARY P. MARCH FU	WARDINOME FA	BALTINIV,
Physician	23a. Par I, Into the disease, or emplications that caused the death. Do realist to only one cause on each line.	not enter the viode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease a. Seizure disorder			Death
	or condition resulting in death) Due to (or as a consequence of):			
à	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	cause. Enter Underlying Cause (Disease or injury that initiated c			
recuted and - transit	events resulting in death) Last Due to (or as a consequence of): d.			
execu an and al - tra	TY HINDENDED TY AMENDED	067 E/10/07 FFF		
SOX 68760, teath certificate be ere attending physician for use as the burial	#1,23a,2/,perMH, IF FEMALE: 23c. If yes, outcome of pregnance	g867, 5/18/07 TT	23d Date of delivery	
587 errifice ling p	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna	incy Month [Day Year
OX (sath ce attence or use	4 Pregnant at time of death 1 Yes 2 No 9 ✓ Unknown 9 Unknown	5 Other (Specify)		
• O. Box 68760, that the death certificate be conditionally by the attending physicial detached for use as the burial by Dhysician Mandi	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
ires that signed!			1 Yes 2 No 3 Prob	oably 4 🗸 Unknown
Records, P.(The law requires tha ficate has been signed , page 2 should be det				topsy findings available
COr e law i			performed? death?	completion of cause of
tal Rections: The certificate ector, page		26.Place of Death (Check	noly one)	es 2 No
Vital Rec ysician: The l his certificate l director, page	examiner? Hospital: 1 Inpatient 2 ER	Other =	g Home 5 Residence 6 Othe	r.
of Vi ling Physi After this funeral dii	27 Mapper of Death 28a Date of Injury 28h	. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
on endin	1 X Natural 5 Pending	1 Yes 2 No		
ivision or Attendather death Director:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru or Town, State)	iral Route Number, City
Division o spital or Attending hours after death neral Director: After filled in by the fune	4 Homicide determined (Specify)		or rown, state)	
		eath occurred at the time, date and place, and	due to the cause(s) and manner as stat	ed.
To the He within 24 within 24 completely	one) 2 Medical Examiner: On the basis of examination and/or and manner stated		29d Date signed (Mo	
	29b. Signature and title of certifier	29c. License number O.C.M.E.	March 12, 2007	mm, Day, rear)
	Aflina Classel, 1118		Water 12, 2007	
	30. Name and address of person who completed cause of death (Item 23a Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201	
Stat				
Registra	The state of the s	Sparle		
		•		

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

07-01710 Robert Taylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Robert Paylor		- For State Registrar	tate or Maryland	•	tificate of D		, ,	teg. No. 201)	7 00148
Physiciar Medical Examin		1. Decedent's Name (First, Mide Robe:		or, 🚅	- -		2. Date of Dea Month March 4,	Day Year	3. Time of Death 0759 hrs
	•	4a. Facility Name (if not instituti	on, give street and number		4b. (City, Town, or Location		4c. County of Dea	th
Funeral		13707 Old National F 5. Social Security Number	•	ge (In yrs. Ia			der 24Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. B	
Director		216-940264	1 M 2 F	40	Yrs.	Months Days Hour	s Min. April	8, 1966 C	ountryMaryland
any		Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Location				10d Inside City Limits
rland -f show	آ ا	Maryland Fred	derick			Airy		(0- 0); (What 0-	1 Yes 2 No
the Mary	Director	13707 Old Nat:	ional Pike,	Apt.		of, Zip Code		Og. Citizen of What Co United Stat	
	ᇹ	11. Marital Status 1 Never Married 2 X	12. Was Deceden	t Ever in U.	S. 13. Was De	ecedent of Hispanic Or specify Cuban, Mexical	igin? (Specify Yes or No n, Puerto Rican, etc.)	o- 14. Race - Ame White, etc.	rican Indian, Black,
fter dea			1 Yes 2 vorced If Yes, Give Year	X No	1 Ye	s 2 No specify	r.	Specify:	White
hours a natura	ed by	15. Decedent's Education (Sp				Jsual Occupation (Give of working life, DO NO		16b. Kind of Business	/Industry
036 ithin 72 ne. r than "	Completed	Elementary/Secondary (0-12)) College (1-4 or	5+)	Tree	Climber		Tree Co	mpany
filed will Hygie ed other	O C	17. Father's Name (First, Middle John H. Tayle					r's Name (First, Middle, une L. Cona	,	
212 ould be d Ments s mark tic even	ալ	19a. Informant's Name/Relation	ship (Type, Print)		(87)	dress (Street and Nu	mber or Rural Route Nu	mber, City or Town, Stat	
and 2 shealth an ealth an earth an trauma	-	JoAnne L. Sur	ber / Sister	20b. F		oyd Road,	Clear Sprin	g, Maryland	
TOPE Pages 1 ent of H int: If if		1 Burial 2 X Crematic	on 3 Removal from S	tate Mon	rematory or other p	olace) matorium, Inc	March 12, 2007	Bethesda,	Maryland
Saltil ermit Departm mporta		21. Signature Funéral Service	e Licensee	M013	22. Name Rober	and Address of Facility A. Pumphrey		/Rockville, I	nc
Physician	+	23a. Part I. Enter the disease, of	or complications that cause		Do not enter the n	est Montgomer node of dying, such as	y Avenue, Rock cardiac or respiratory ari	rest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	Mathadana						Death
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	듸	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	F						
uted nd ransit	Exa	events resulting in death) Last	Due to (or as a cons	sequence of	f):				<u></u>
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certificate be executed nding physician and as as the burial - trans		IF FEMALE: 3b. Was decedent pregnant in past 12 months?	the 1 Live birth	ine or preg	2 Fetal o		ic pregnancy	23d. Date of delive Month	ry Day Year
Box 687 e death certific the attending p ed for use as th	Physician/	1 Yes 2 No 9 U	nknown 9 Unknown	t time of de	ath 5 Other	(Specify)			
, £ >£	<u>a</u>	Part II. Other significant cond	itions contributing to dea	th but not re	esulting in the unde	erlying cause given in F	Part I. 23e. Did t	obacco use contribute t	o the cause of death?
Division of Vital Records, P.O ral or Attending Physician: The law requires that tress after death. "al Director: After this certificate has been signed by leed in by the funeral director, page 2 should be detacted in by the funeral director, page 2.	eted	Cocaine use					24a. Was		autopsy findings available completion of cause of
Recol	Completed						perfo	ormed? death?	
ician: ician: s certific	8	25. Was case referred to medic examiner?	et to an italy	ient 2	ER/Outpatient 3	-Other -	(Check only one) Nursing Home 5	Residence 6 🗸 Oth	er: Scene
of V ng Phys After thi	암	1 V Yes 2 No 27. Manner of Death	28a. Date of In (Month, Day	jury	28b. Time of Injur	y 28c. Injury at Wo	k? 28d. Describe	how injury occurred	
Sion Attendi	catio		estigation Fnd 3/4/		Fnd 7:30 a	actory, office building,		(Street and Number or F	Rural Route Number, City
Divi	Certification:		uld not be ermined (Specify)		at home				National Pike Apt C
	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of a caminer: On the basis of ex	amination a	ge, death occurred ind/or investigation.	at the time, date and p	lace, and due to the cau	ise(s) and manner as sta e and place, and due to	ated the cause(s)
To the within To the comple	Med	29b Signature and title of certif	and manner stated			29c. License numbe		29d. Date signed (M	
		Potu lu	mi - to	Wel	- 1	O.C.M.E.		March 5, 2007	
07		30. Name and address of person Patricia Aronica-Poll	ak MD. Assistant	Medical I	Examiner 1	I1 Penn Street, B	altimore, MD 2120	01	
Sta Registr	te ar	31. Date filed (Month, Day, Year MAR 1 5	2007 132. Registr	ar's Signatu	Tre Special				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician Month Year LUSALIF SCP M 2007 10 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner 2408 SYLVALE ROAD BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 219-10-3970 80 06/28/1926 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland reent of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notitiled at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 21209 2408 SYLVALE ROAD U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 LEGAL SECRETARY LAW OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MEYER GOLDBERG SOPHIE **RUDO** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNE PASTERNACK / DAUGHTER 2408 SYLVALE ROAD - BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ARI CINGTON CONG. Department of Important: If it any Injury or o 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donatiop 5 □ Other (Specify) 03/13/2007 BALTIMORE, MD r f Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only whons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DNEUMONIA 2 DAYS disease or condition resulting in death) /Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buris by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 3 Probably 4 Unknown Completed HYDROCEPHALUS Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy 2 No 1□ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this after death.

Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not b 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) detern 4 Homicide To the Hospital within 24 hours at To the Funeral C 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and matrier stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 3-10-07 TOWSON MD 21204 State Registrar

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician PM March 10, 2007 9:32 Sadie Eustace Vermilyea /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care Potomac Potomac Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Min Months Days Hours 1 ☐ M 2 ☑ F Yrs. 99 December 18, 1907 New York Director 061-10-7523 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ₩ No Director Bethesda Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20814 United States 23a 4820 Montgomery Lane #301 Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, ltems ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🛣 No Specify: White Specify: ģ 3 ₩ Widowed 4 Divorced natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H ie marked of ပ William Dugan Lucy Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 4820 Montgomery Lane #301, Bethesda, Maryland 20814 Gail Quigley / Daughter : If Item 27 or other t March 15, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of h cemetery, crematory or other place) Gate of Heaven 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 2007 4 ☐ Donation 5 ☐ Other (Specify) Filver Spring, Maryland Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Ucensee M01473 23a. Parti. Enter the disease shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between pneumonia Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, is amy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dile to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical Sas attending properties as 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown Ö 9 III Unknown ۵. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ preumonic 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No certificate 1 Yes 1 Yes 2. No Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 Tyes this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how infury occurred 27. Manner of Death 28b. Time of Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No М investigation 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated icai 29a. Certifier 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 311107 00054566 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 14702 Cherry heaf terrace silverspring un 20906 Suhitha Bhogavilli 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

1 - For State Registrar 1. Decedent's

Funeral Director

Be Completed by

은

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

DR.

TARIQ MAHMOOD

31. Date filed (Month, Day, Year) MAR 1 5 2007

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.

Please '	Type or Prin State of Ma					-		egible.	
For State Registrar 1. Decedent's Name (First, Middle, Las		-		ite of Dea		, ,	leg. No.	2007	0 0 1 4 0
John B. Walls	•					March	14°,	2007	5:18 AM
4a. Facility Name (If not institution, give				y, Town, or Locati	ion of Death			ounty of Death	
Stella Maris 5. Social Security Number 6. Se		(In yrs. last birt		imonium er1 Year If Un	der 24 Hrs.	8. Date of Birth	h	Baltimo1	Clace (State or Foreign
	X M 2□F		Yrs. Month	s Days Hou	rs Min.	June 2	9,192	27 Ma1	yland
10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
Maryland Baltimo	re	Ca	tonsvi]	lle					1 ☐ Yes 2 💢 No
715 Maiden Choice	Lane		10f. 2	Zip Code 21228			10g. Citize	of What Cou USA	ntry?
11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:			cedent of Hispanic pecify Cuban, Mex 2 No Spec		ecify Yes or No- Rican, etc.)		1. Race - Ameri Black, White, Specify: Wh:	etc.
15. Decedent's Ed	ucation	16a.	Decedent's Us	sual Occupation			16b. Kind	d of Business/Ir	dustry
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT Banke	work done during i use retired) 2 °	most of work	ang	I	Banking	
17. Father's Name (First, Middle, Last)		1		18. M	other's Nam	e (First, Middle,	Maiden S	urname)	
Lawson B. Walla	ace					lred Fre			
19a. Informant's Name/Relationship (7				ess (Street and Nu					
Joan S. Wallace	e, Wife		5 Maide Disposition (N			Catons		e, Mary	Land 21228
1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemeter	y, crematory o	r other place) ory Inc				•	Maryland
21. Signature of Funeral Service Licen Thomas Gregor	see		MacNa 301 I	abb fünei rederick	raï Ho k Road	ome, P.A L Catons	ville	e, Maryl	land 21228
shock, or heart failure. List only of the shock of heart failure. List only of the shock of the	a. CHRONIC Due to (or as a b. Due to (or 35 c		f):	PULMONARY	7 DISE	ASE			Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic 5 □ Other				23	d. Date of deliv Month	ery Day Year
Part II. Other significant conditions of	ontributing to death bu	it not resulting in	the underlying	g cause given in P	art I.	1 □ Y 24a. Was a autop perfor	es 2□ an sy rmed?	No 3 ☐ Pro	he cause of death? bably 4\text{Unknown} psy findings available impletion of cause of 2 \text{No}
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2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, far	М	1 ☐ Yes	2 🗌 No	28f. Location (S City or Tow	Street and vn, State)	Number or Rur	al Route Number,
	ysician: To the best of liner: On the basis of and manner sta	examination and							
29b. Signature and title of certifier)		2	29c. License numb	oer		29d. Date	signed (Month,	Day, Year)
30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Print)	11 ()	165		-	11.1101	

State

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

legistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland /	Department of He	alth and Mental	Hygiana

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Physicia		Registrar 1. Decedent's Name (First, Middle, I	Last)							Date of D		-		3. Time of Death
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Baltimore, MD oemit Pages I and 2 sho Department of Health and important: If item 27 is njury or other traumati	ı	20a. Method of Disposition			Place of Dispos crematory or oth	ition (Name				ate				Town, State
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2		30. Name and address of person water Zabiullah Ali, M.D. As	ho completed cause of de ssistant Medical Exa			n Street	Baltin	nore M	D 2120	1				
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Dhusi		Decedent's Name (First, Middle, Last)							2. Date of D	eath	ay Year	3. Time o	of Death
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Exam		4a. Facility Name (If not institution, give s 2603 East Chase St 5. Social Security Number 6. Sex		In yrs. last birth	Balt	imore	Location o		8. Date of Bi		c. County of Deat		F/-
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at any once.		19a. Informant's Name/Relationship (Ty) Blondell Louise Ya	· .		Mailing Address 3 East						or Town, State, 2	ip Code)	
es 1 a of Hear filtern		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ R	omeyal from State	20b. Place of I					ate		Location - City or	Town, State	
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2		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (T	ype, Print)	0-10	ans	- 57	L Ba	14.	mD	1/23	7

State Registrar

		-	For State Registrar	State o	f Marylan			t of Health e of Deat			giene Reg. No.	007	0.8	5 1
			Decedent's Name (First, Middle,					-		2. Date of De Month	Day	Year	3. Time of	
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				6. Sex	7. Age (In yrs.		If Unde	1 Year If Und	er 24 Hrs.	8. Date of Bir	th	a Birt	thplace (State of	or Foreign
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ē,	theal		20a. Method of Disposition	<u>ak - Si</u>	20b. F	Place of Disponentery, crei	sition (Na	gh St.	pare	Date	20c. Loca	ition - City or	Town, State	-4
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperfunent of Health and Mental Hygiens. Deperfunent of Health and Mental Hygiens Hyperson in Thems 23a or 28a-f show Important: If Item 27 Is marked other then "naturel", or Items 23a or 28a-f show Important: If Item 23a or 28a-f show Important if Item 1 and Injury or other traumatic event, Item Medical Examinat must be notified at angel.		21. Signature of Funeral Service L	icensee	101			nd Address of Fa						
_	89E = 8		1 tomb 1	Jolack	8			Dundalk				e, Mo		
П			23a. Part1. Enter the disease, brashock, or heart failure. List	complications that only one cause on	each line.							1/0	Approxima Interval Be Onset and	tween Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Punt	(or as a consec	elel	FOY	ie ca	CDIOV	HSCUL	ATC 1	DI SEKSE	OVER	S 4EM
	Examiner			A	12 H	51 M	FR	DISE	ASE	5			OVER	SYETES
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Box (death certifica e attending ph id for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant		atcome of pregnation		Testania s	V-0000000			23	d. Date of de	,	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of o		⊒Ectopic p ⊒ Other (s					Month	Day	Year
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Ž	S S D	To B	examiner? 1 □ Yes 2 🔀 No		Inpatient 2	ER/Outpatie	nt 3 🗆 D	OA Other: 4	Nursing Ho	me 5□Res	idence 6 (ASS1 XOther (Spe	stedL	iving
0	fer fer		27. Manner of Death 1 ☑Natural 5 ☐ Pendin		of Injury nth, Day Year)	28b. Time o Injury		28c. Injury at Work?		28d. Describe	how injury	berrussc		
Division	Attending r death. ector: After by the fune	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be 280 Place	e of Injury - At h	ome tarm st	M facto	1 Tes 2		28f. Location	(Street and	Number or F	tural Route Nur	mber.
oi≤	after Direct	Certification:	4 Homicide determ	build	ding, etc. (Speci	fy)	reot, racto	y, omou			wn, State)			
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	thin 2 the f	Medical	one) 29b. Signature and title of ceptifier	and ma	nner stated.		29	c. License numb	er		29d. Date	signed (Mon	th, Dey, Year)	
	F 3 F 8		> Puta	Or.Va	Vara	3		DØB16	389	7	MAR	CH 1	4,20	07
1	7		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type	Print)							
(<i>y</i>		29b. Signature and title of certifier 30. Name and address of person PERTECTION 31. Date filed (Month, Day, Year)	VALARA	O,M.L	0, 17	16 h	HR PORC	KOA	DSu.	105	FAULS7	ONMO	2/047
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	5 2007	n istrar's Sign	ature	Second.	D						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Joseph Leroy Alvey 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's Lanham Doctors Community Hospital 8. Date of Birth (Month, Day, Year Jan • 21 • If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Year) 1920 Washington, DC Days Hours Min Months 215-14-7008 87 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits tyF]Yes 2∏No Hyattsville Maryland| Prince Geroge's 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20781 USA 5013 55th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 NoWWII 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 2 Married 1 ☐ Yes 2 🖺 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government Fire Fighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose E. Hancock Edward Alvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1915 Winding Ridge Trail, Knoxville, TN 37922 Brenda J. Young - Daughter/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 3/3/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 4739 Baltimore Ave. 21. Signatur and Funeral Service Licamee 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular accident disease or condition resulting in death) Unknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an autopsy performed 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

requires that the death certificate be executed

or Attending Physician:

death.

after

hours

24

Division or Vital Records, P.O. Box 68760,

Department of H Important: If ite any Injury or ot

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

6 must be

7 is marked other than "natural", or iten traumatic event, the Medical Examiner

1 and 2 should be filed within Health and Mental Hygiene. Sm 27 is marked other than

72 hours

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examine burial-tran physician Physician/Medical the SS use atter for u the signed by to the sign of the s þ Completed has e 2 page certificate Be ို this After Certification: the Funeral Director: npletely filled in by the

To the Hospital

Medical 29b. Signature and title of certifier

State

1 ☐ Yes 2 🛣 No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 5 ☐ Pending investigation (Month, Day Year) 6 Could not be determined

28b. Time of

28c. Injury at Work?

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Ave Suit 3-41 silver spring 120 20802

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1:40 PM Claude Allen EBRUARY 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28, 1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours **№** M 2□ F 578-82-2436 71 Jamaica, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County t of Health and Mental Hygiene. If Item 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 AYes 2 No Director MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20781 5418 Gallatin Street Jamaica, WI Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11 Marital Status Black, White, etc. 1¥ Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be N/A N/A2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline Jones - Landlord 5418 Gallatin Street, Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 03/03/07 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Latney's Funeral Home Malph Dr Mams 3831 Georgia Avenue, NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastalic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit and Due to (or as a consequence of): physician Physician/Medical as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2€ No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending

Hospital

death with the Maryland

72 hours after

Pages 1 and 2 should be filed within

land 21215-0036

timore,

funeral director After 24 hours after death. filled in by the

5 ☐ Pending investigation 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

45660 ress of person who completed cause of death (Item 23a) (Type, Print) Dpinder Singh,

and manner stated.

State Registrar

completely

within 2.

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Thomicide

MAR 0 1 2007



			1 - For State Registrer	State of W	Ce	ertificate of			eg. No.2 0 0 1	7 08 154
	Physici	ian	Decedent's Name (First, Middle, A 1 -t		A 7			2. Date of Dea Month	Day Yea	3. Time of Death
	/Medi	cal	Alice	Alfreda		4.0.7	.1	March 1		11:00р. м
	Examir	ner	4a. Facility Name (If not institution,		,	William	r Location of Death		4c. County of De Washing	
	Funeral		Williamsport Nu 5. Social Security Number 6		ge (In yrs. last birthda	/) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		linthplace (State or Foreign Country)
	Director		231-18-5723	1 □ M 2 🖾 F	82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) July 20	,1924 Vi	rginia
Т	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	_ocation				10d. Inside City Limits
	Maryli	ō	Maryland Washin	gton	Beaver					1 □Yes 2∑No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
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Maryland 21215-0036	72 hou	ted	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occup	ation	dina.	16b. Kind of Busines	ss/Industry
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ore,	of He		20a. Method of Disposition 1 □ Burial 2 ② Cremation 3	Chambral from State	20b. Place of Dis	oosition (Name of ematory or other place	(e) Marcl		20c. Location - City	or Town, State 26/6
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Baltimore,	permit. Pages Department of Important: If it any injury or once		21. Signature of Funeral Service Li	Castal .		22. Name and Addre			Funeral l	Home aryland 21740
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			IF FEMALE:	23c. If yes, outcome	a of pregnancy				20d Date of d	tolina.
P.O. Box	es that the death certigned by the attendin be detached tor use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1☐Live birth	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	Day Year
	s that ned by e deta		Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
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of		<u>٦</u>	1 Yes 2 No	Hospital:			4 Mursing H		ence 6 Other (Sp	pecify)
5	ding h. After tuner	tion	1 Vatural 5 Pending 2 Accident investiga	28a. Date of Inj (Month, Da	ury 28b. Time ay Year) Injury	Wor	yat k? Yes 2 □ No	280. Describe no	ow injury occurred	
Division	Atten ar deal ector; by the	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of Ir	ijury - At home, farm, stc. (Specify)		_	28f. Location (Si City or Town	treet and Number or	Rural Route Number,
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	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the besi aminer: On the basis and manner s	of examination and/or	ath occurred at the tir investigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To the comp	Z	29b. Signature and title of certifier			29c. Licens			9d. Date signed (Mo	* * * * * * * * * * * * * * * * * * * *
•			Cynthia k	auther - Si			451	<i>f</i>	March 2	12007
, <i>L</i>	11 11		30. Name and address of person w		death (Item 23a) (Type	Print)	ursina t	tome. 19	54 North	Artizan + Marylan
<u>ي</u>	4-4		21 Date filed (Month Day Year)	r-Sands	rar's Signature	HI2hora	15	treet, W	Manspor	+, Marylan
	Sta Registi		MAR 0 5	2007	w B. A	pede				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Irwin Axelrod /Medical February 27. 2007 6:00 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months Days Hours 1 M 2 ☐ F Director 063-22-4865 76 Aug. 10, 1930 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at NY 1 ☐ Yes 2 ☐XNo Kings Director Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any Inury or other traumatic event, the Medical Examiner must be not any Inury or other traumatic event, the Medical Examiner must be not Apt. 2F 3033 Coney Island Ave. 11235 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Joseph Axelrod Lena Hochfelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Axelrod/ Brother 914 S. Belgrade Rd., Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any injury or conce 1 🕅 Burial 2 □ Cremation 3 🖫 Removal from State New Montefiore Cem 2/28/2007 4 ☐ Donation 5 ☐ Other (Specify) Farmingdale, NY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pleural Effusion **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No. the 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advanced Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Severe Peripheral Vascular Disease 24a. Was an has autopsy performed? te Chronic Kidney Disease 1□ Yes 2√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hxelrod, Hospital: 1 Inpatient
28a. Date of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natasha P. Haag M.D. 8600 Old Georgetown Rd., Bethesda, MD 20814 31. Date filed (Month, Day, Year) FEB 2 8 2007 3 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryland		artment of H		Mental Hy	giene	07 08156
****	Physicia /Medic		1. Decedent's Name (First, Middle, La	st) Nams				2. Date of De Month Februa	ry 24, 20	
	Examin Funeral	er	4a. Facility Name (If not institution, given 13120 Fernedge 5. Social Security Number 6. S	Road		4b. City, Town, or Silver If Under I Year Months Days		8. Date of Bit	Montgo	
المواد	Director		219-82-9609 Usual Residence of Decedent	82	Yrs.			Jan. 28	1925	Washington, DC
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Maryland 10e. Street and Number	Montgomery 10c. City	, Town or Lo	Silver Sp	oring		10g. Citizen of W	10d. Inside City Limits 1 □ Yes 2 ☑ No That Country?
	ath wit	ralD	13120 Fernedge Ro				20906			USA
30	rs after des l', or items xaminer m	by Funeral	11. Maritał Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2XXNO If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ x No	ispanic Origin? (§ an, Mexican, Puei Specify:	Specify Yes or No rto Rican, etc.)	Black	- American Indian, c, White, etc. White
0500-C17	hin 72 hou e. an "natura Medical E	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wo d)	orking	16b. Kind of Bu	siness/Industry
V	e filed within 7 al Hygiene. I other than "r vent, the Med	Con		2		Homen		(F) + A4: 1.0		Own Home
yland	ould be fill Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last Charles Erwin				Ger	trude Ch		
s, mar	and 2 shi lealth and m 27 is m		19a. Informant's Name/Relationship (Charles F. Adams	/ Son	14111	ng Address (Street Chelmsfo esition (Name of			lle, MD	20853
altimore	Pages 1 ment of F ant; if ite lury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Bemoval from State	emetery, crei ropoli	matory or other plac tan Crema	tory Fe	b. 26, 2007	Alexand	City or Town, State
Dall	permit. Depart Import any inj		21. Signar to 1 Funeral Service Lice	Cole	5		sity Bl	vd, W.,	Silver S	nc. pring, MD 2090
	Physician /Medical	0 1	23a. Part1. Enter the disease, or com shock, or heart failure. List any Immediate Cause (Final disease or condition resulting in death)	blications that caused the death one cause on each line. a. Chronic Ati Due to (or as a consequ	cial F			ac or respiratory a	arrest,	Approximate Interval Between Onset and Death
(A)	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b. Coronary And Due to (or as a consequence)	rt erv uence off:	Disease				12 Years
8/00,	cate be executed obysician and the burial-transit	lical	that initiated events resulting in death) Last	c. Hypertensic Due to (or as a consequence)	on uence of):					12 Years
O. Box 6	the death certificate y the aftending physi ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3[□Ectopic pregnancy □ Other (specify) _	/		23d. Date Mor	e of delivery hth Day Year
cords, P	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions Cardiomegaly , Hy	•	•	, ,				ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Ď Ľ	m (0 a)	Completed	of Left Breast					24a. Was auto perf 1∐ Yes	opsy pormed? d	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
n or vital	ding Physician: The Is h. After this certificate ha funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 No 27. Manner of Death 11 N N N N N N N N N N N N N N N N N N	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		er: 4 Nursing		one) idence 6 □Othe how injury occurre	
DIVISION	Atten er deat rector; by the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 280 Place of injury - At ho			Yes 2 No		(Street and Numbe wn, State)	er or Rural Route Number,
	o the Hospital or vithin 24 hours afte o the Funeral Dii ompletely filled in	edical (hysician: To the best of my kno mIner: On the basis of examina and manner stated.						
	withii comp	Me	29b. Signature and title of certifier	rera, M.D.		29c. Licens	e number 1662			(Month, Day, Year)
	5		30. Name and addless of person who Wilhelmina Camin	·		Print) n Street,	Rockvil	lle, MD	20853	
i	Sta Registi		31. Date filed (Month Day, Year)	32 degistrar's Signa	ture	ade				

		1	For State Registrar	State of Maryland		artment of Hetificate of E			ene g. No. 7	08157
			. Decedent's Name (First, Middle, Last)		-			2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Geo	orge L. Adams	, Jr.			February		6:00 P ^M
	/Medic Examin		a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death	1	4c. County of Deetl	1
			5703 Phelps Luck Di			Columb		D. D. J. of Birth	Howard	place (Stete or Foreign
	Funeral Director		219 38 6/20	7. Age (In yrs. la	yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 24)	Yeer) Co.	shington DC
	pu k	-	Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f show if must be notified at	.		Co	lumbia	a				1 ☐ Yes 2¶ No
	the N	Director	MD Howard 10e, Street and Number		TUINDI	10f. Zip Code		10	g. Citizen of What Co	untry?
	3a or		5703 Phelps Luck D	rive		21045			United St	tates
	ms 2	Funeral		. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
	or Ite	by Fur	t ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🔀 No	Specify:		Specify:	Vhite
Maryland 21215-0036	filed within 72 hours Hygiene. sther then "natural", ent, the Madical Exa		15. Decedent's Educa (Specify only highest grade	ition	16a. Deced	dent's Usual Occupa	ation Juring most of wo		16b. Kind of Business/	Industry
215	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)		D 1 1 1	
2	ed wil	Con	12		Custo	omer Serv		esent. ne (First, Middle, A	Printii	ng
nd	ital Hy	Be	17. Father's Name (First, Middle, Last)	~		!	Winfred		naiden damand,	
<u>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </u>	should be nd Mental s marked o umatic eve	ဥ	George L. Adams, S. 19a. Informant's Name/Relationship (Type		19h Maili	ng Address (Street a			City or Town, State, 2	Zip Code)
Mar	12 sh h and 7 is m traum		Ellen J. Adams/Wife						ia, MD 210	
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic e one.	-	20a. Method of Disposition	20b. Pi	ace of Dispo	osition (Name of matory or other place			20c. Location - City or	
<u>o</u>	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	•	ematory	1	8-2007	Catonsvil	le, MD
Baltimore,	nit. Paritme		21. Signature of Funeral Service Licensee				ss of Facility Ha	rry H. W	itzke's Far	mily FH Inc.
ä	Depa Impo eny ii		> Show Collis	- Wellich					icott City	
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-	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	uence of):					YEARS
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	es pe	٥	DIABETES MELLI					. 1□Y	es 2⊡No 3XP	robably 4 Unknown
Vital Records,	v requir been s should	Completed						7	n 24b. Were a	utopsy findings available
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al			SICK SINUS SYND!	OME			26 Place of De	1 ☐ Yes eath (Check only or		2 2 2 3 1 0
ΖÏ	Physician: this certific ral director,	o Be	avaminar?	ospital:	ER/Outpatie	ent 3 DOA Ott			ence 6 Other (Spe	ecify)
of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		ry at	28d. Describe h	ow injury occurred	
ion	Attending or death. ector: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Worth, Day rear)			Yes 2 □ No			
Division of	or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, s y)	treet, factory, office		28f. Location (S City or Tow	treet and Number or F m, State)	lural Route Number,
tual	Hospital 24 hours Funeral tely filled	edicai Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ician: To the best of my knoter: On the basis of examina and manner stated.	owledge, dea ation and/or i	ath occurred at the ti nvestigation, in my o	me, date and place opinion, death occ	ce, and due to the courred at the time, of	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
	To the within 2 To the complex	Med	29b. Signature and title of certified			29c. Licens	se number		29d. Date signed (Mor	oth, Dey, Year)
	F 3 F 8		2 Chr.	· huy		D 3	38296		February	28, 2007
1	a2		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type	a, Print)				
6			JOSEPH GIBBONS	MD 81861	ARKI	seown Ro	Ad, SuiT	13 102 Er	KRIDGE, N	18 21075
į,	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	how.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State	of Marylan	-	irtment of F <i>tificate of</i>		l Mental Hy	•		
			Registrar 1. Decedent's Name (First, Midd	lle, Last)		001	imodic or	Death	2. Date of D		2007	3. Time of Death
	Physicia /Medic		H.B. Bel	.1					Month March	Day 4 . 2	Year 0 0 7	1630 M
3	Examin		4a. Facility Name (If not institution	on, give street and nu	mber)		4b. City, Town, o	r Location of De			ounty of Death	
			Hospice and 5. Social Security Number	Gilchris 6. Sex	t Cent		TOV	VSON If Under 24 H	rs. 8. Date of Bi	Ba	ltimo:	place (State or Foreign
	Funeral Director		249-50-0840	1 ½ M 2□ F	7. Age (117)7-0. 1	73 Yrs.	Months Days	Hours Mi		ay, Yea <i>r)</i>	Cou	intry)
	D		Usual Residence of Decedent		140 00			1	ban. 9	1774		
	arylar show ed at	Ž	10a. State 10b. County	У		, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	Director	Md .		B	altim	10f. Zip Code			10a, Citize	en of What Cou	
	3a or	Ö	2416 Marbour	ne Ave	#2C		1 2 2 2 2	230		IIni+	~9 C+-	. +
	ems 2	Funeral	11. Marital Status		edent Ever in U.	S. 13. V			(Specify Yes or Nerto Rican, etc.)	0- 14	ed Sta 1. Race - Amer Black, White	ican Indian,
36	s after	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☑ Divorce	rried 1 ☐ Yes	2 X No ive		I∐Yes 2 X No	Specify:	,		Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ed b		d Year or I nt's Education	Jales:	16a. Deced	lent's Usual Occup	oation		16b. Kind	Bla d of Business/li	
215	hin 72 3. an "na Medic	Completed	(Specify only high: Elementary/Secondary (0-12)	est grade completed,	1-4or 5+)	(Give life, L	kind of work done OO NOT use retire	during most of и d)	orking			
	ed wit ygiene ygiene rer the	Con	12		,	Profe	ssional				ivate	
and	ntal H ed oth even	Be	17. Father's Name (First, Middle Athel Bell	e, Last)				_	ame (First, Middle		urname)	
Maryland	should be filed vand Mental Hygies marked other tumatic event, th	၉	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address (Street		e Baxte Rural Route Numi		Town. State. Z	ip Code)
≥	alth ar 27 is or trau		Renee Bell A		daught	7	08 Craw xon Hil	fords	treet.	, ,	,	,,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. P	lace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Loca	ation - City or T	own, State
Ē	Pag tment tant; I		4 Donation 5 ☐ Other (Specify)		coln	Mem. Ce	m. 3/	9/07	Suit	land,	Md.
Bai	permit Depar Impor any in once,		21. Signature of Funeral Service	e Licensee	11-	2	. Name and Addre		Hodges	& Ed	wards	F.H.
			23a. Part1. Enter the disease, of	or complications that	caused the death						and, M	Id 20746 Approximate Interval Between
	Physician		shock, or heart failure. List disease or condition	st only one cause on	each line.	1	Car	cer	-			Onset and Death
1	/Medical		resulting in death)	a. ue to	(or as a consequ	uence of):	Can				-	gais
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b	/							
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o.	the d	nysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unki								
S, T	ires that the death cer signed by the attendir d be detached for use	by PI	Part II. Other significant condit	tions contributing to	death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco us		the cause of death?
ord	w require been sig should b	ted t							1 🗆	Yes 2□	No 3∏Pro	obably 4 Unknown
Sec.	e law has be	Completed							24a. Was	ppsy	prior to c	topsy findings available ompletion of cause of
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₹	ysician: The lavis certificate has director, page 2:	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 □	ER/Outpatien	t 3 DOA Oth	or.	eath <i>(Check only</i> Home 5 Res		ther (Spec	100/A / 12 2/ 1
יסר	ding Phy	n: To	27. Manner of eath	28a. Date		28b. Time of Injury			28d. Describe	_		"IN WSP CO
Sion	tendir eath. or: Af	catio	2 ☐ Accident inves	tigation			M 1	Yes 2 □ No				
Division or Vital Records,	or Attendatter death Director; in by the	Certification:		min od 200. Flac	e of injury - At ho ling, etc. (Specif)	ome, farm, str v)	eet, factory, office		28f. Location City or To	(Street and own, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as			ing Physician: To th								
	he Ho in 24 h he Fu pietel)	Medical	(Check only 2 Medica one)	I Examiner: On the and ma	basis of examina nner stated.	tion and/or in	vestigation, in my	opinion, death o	ocurred at the time	, date and p	place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifi	er u 1 1 1	~		29c. Licens	100 0	7		signed (Month	
					<u> </u>	00a) (T	Duint)	7020	>	pran	N 6	
	la		30. Name and address of perso	HANLIFE	Se of death (Item	23a) (Type,	N. Ch.	12/02 E	ST WA	Duo	70 W	2007
			31. Date filed (A triff), day Yea	1007	Registrar's % na	IA	9 a	201				- Viet

			For State Registrar	State of M	aryland / Dep		leaith and I	Mental Hy	•	07 08159
	Physici /Medic	an	Decedent's Name (First, Middle, Inc.) Nelson Jere	emiah Bowm	an			2. Date of De Month March	Day	Year 3. Time of Death 2157 M
1	Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	r Location of Death	1	4c. County	
			Harford Memoria			-	de Grace			ford
	Funeral Director		5. Social Security Number 6 216-12-9893 Usual Residence of Decedent	.Sex 7. Ag 1 <mark>M</mark> 2 □ F	e (In yrs. last birthday 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Oct, 23	y, Year)	9. Birthplace (State or Foreigr Country) Maryland
Maryland	of show	tor	10a. State 10b. County	arford	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 XNo
h the	128	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Country?
č.	23a c	alD	4131 Webster Ro	oad		21078			U.S.	Α.
5-0036 72 hours after death with the Maryland	natural, or items 23e or 28e-f show idical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 1 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13. No WWII	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - American Indian, ck, White, etc. Y:White
1215-0(within 72 ho	ne. han "nature Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+) life.	edent's Usual Occup e kind of work done DO NOT use retired 1 Servant	d) -	king	16b. Kind of Bi	usiness/Industry
Maryland 21215-0036	tal Hygi d other svent, t	To Be Co	17. Father's Name (First, Middle, La Warren N. Bowma		CIVI	Dorvane	18. Mother's Nan Lenora			
	alth and M 27 is mai r traumal		19a. Informant's Name/Relationship Lenora Monteith			ling Address (Street C York Wo			er, City or Town, t, Ind.	State, Zip Code) 46516
Baltimore,	in the re		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			osition (Name of ematory or other place like Presb	. 3/(4/	Date /07		City or Town, State
Balti	Department Important: any injury o		21. Signature of Funeral Service Lin	•		22. Name and Addre	1	neral Ho	me, P.A 1-3399	•
	nysician Medical xaminer		23a. Part1. Enter the disease, or construction of the construction	a. Due to (or as	d the death. Do not entine. THE LANGE A CONSEQUENCE OF:	lammi	11	c or respiratory a		Approximate Interval Between Onso and State Park
760, %	sician and s burial-transit	sal Examiner	any, leading to intribute cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a definsequence of):	reduction	metu			?48 hour
Geath certificat	by the attending phy tached for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify)	1			ate of delivery onth Day Year
rds, P	n signed b	۵	Part II. Other significant condition	Contributing to death	out not resulting in the	pe (en in Part I.		obacco use cont Yes 2 □ No	tribute to the cause of death?
Vital Records, P.O		e Completed	Passible &	artery cute in	yocard	ial inf	arctio	24a. Was autor performance 1 Yes	omed 2 No	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
o à	After this funeral di	atlon: To B	examiner? 1	Hospital: 1 Inpati 28a. Date of Inj (Month, Date)	urv 28b. Time	of 28c. Injur	ner: 4 ☐ Nursing H	lome 5 ☐ Resi	dence 6 (10th	
5 5	부분드	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Place of in	jury - At home, farm, s tc. (Specify)	treet, factory, office		28f. Location (- City or Tot		ber or Rural Route Number,
To the Hospital	within 24 hours after of To the Funeral Dirac completely filled in by	edical	29a. Certifier (Check only one)	Physician: To the besi caminer. On the basis of and manner's	d examination and or	ath occurred at the timestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and made and place,	anner as stated. and due to the cause(s)
) [Σ	29b. Signature and title of certifies	Buch	5 Mis		3694	- 1-	29d. Date signe	H /Os 2007
	to j	1	30. Name and address of person w	KK, Mi	D. UNI	ON AVEA	ORD MEN	WRE)	te Gra	LL 21078
4	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	Regist	rar's Signature	العظيمة	·			

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ам Battle February 27, 2007 4:30 C. James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly

Age (In yrs. last birthday) If Under 1 Year I Under 24 Hrs.

Months Days Hours Min. Prince George's 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2 □ F Yrs. 66 Director 238-64-7264 Dec. 2, 1940 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28e-f ehow the Madical Examinat must be notified at Prince George's New Carrollton 1 X Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8311 Oliver Street 20784 U.S. death v or iteme 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours atler and of Heelih and Mental Hygiene. And if Item 27 is marked other than "natural," or Ite ary or other traumatic event, in a Madical Escripta 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned African American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: à 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Almeta Robinson James Douglas Battle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Battle 8311 Oliver Street, New Carrollton, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Depertment of Important: If eny injury or once. Riverdale, MD 3-2-07 Riverdale Park Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bornette & Asoc. Funeral Home Inc. 21. Signature of Funeral Service Licensee 2504 28th St., N.E., WDC 20018 Re 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Lung Cancer /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours effer death.
Funeral Director: After this certificate has been signed by the attending physicien and lely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Sepsis -Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Pneumonia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Pulmonary Hypertension 1 ☐ Yes XXNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Alnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C completely filled i 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057636 February 27, 2007 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ate filed (Month

MAR 0 2 2007

Patricia Eben, MD 3001 Hospital Dr., Cheverly, MD 20785

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:47P M Blumberg February 27, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 7403 Baltimore Avenue Takoma Park Montgomery 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 15, 1914 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 F 335-40-9747 Director Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at MD Montgomery Takoma Park X□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7403 Baltimore Avenue 20912 United states Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 █**X**No If Yes, Give Year or Dates: White 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Herman Gussie Boris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carol H. Sweig - Daughter 7403 Baltimore Avenue Takoma Park MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Memorial Park Cemetery 3/2/07 4 ☐ Donation 5 ☐ Other (Specify) Skokie, IL 22. Name and Address of Facility Danzansky-Goldberg Memorial 21. Signature of Funeral Service Licensee Chapel Inc 1170 Rockville Pike Rockville MD 20852 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronice Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner aftending physician and for use as the burial-transi Due to (or as a consequence of) the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an autopsy perform 2 👿 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 s

nthia m Filliams DO H0058032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams DO Montgomery County Hospice Rockville MD 20855 Road

and manner stated

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 0 1 2007



Medical

State

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

2-28-2009

Baltimore, Maryland 21215-0036

	1 - For State Registrar	C	ertificate of		, ,	No. 200	7 00	16
	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Yea	3. Time of D	eath
ian	Charles A.	Bervine				7 28, 20		a M
ical ner	4a. Facility Name (If not institution, give street ar	nd number)	4b. City, Town,	or Location of Death	1	4c. County of De	eath	
iici	Conogia Inwhill Conta			il Cn	cina	Mont		
	Genesis Layhill Centers 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda		ilver Sp	8. Date of Birth		Gomery Birthplace (State or	Foreian
	1 € M 2] F Yrs.	Months Days	Hours Min.	(Month, Day, Yo	ear)	Country)	, or orgin
	128-16-5998 Usual Residence of Decedent	81			Nov. 14.	1925 1	/irginia	
	10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City	Limits
<u> </u>							1 □Yes	2 [X No
당	Maryland Montgomery	Sí:	lver Sprin	g				
l'ë	10e. Street and Number		10f. Zip Code		10g	. Citizen of What	Country?	
a E	1010 Stirling Road			20901		USZ		
by Funeral Director	11 Marital Status 12. Was	Decedent Ever in U.S. 1	3. Was Decedent of I		pecify Yes or No-	14. Race - A	merican Indian,	
뎚		ed Forces? Yes 2 ☐ No			o Hican, etc.)	Black, W	hite, etc.	
2	3 ☑ Widowed 4 ☐ Divorced Yea	es, Give r or Dates:1944-46	1 ☐ Yes 2 X No	Specify:		Specify:	Black	
뎡	15. Decedent's Education		ecedent's Usual Occu	nation	16	b. Kind of Busine		
Completed	(Specify only highest grade comple	eted) (G	live kind of work done fe. DO NOT use retire	during most of wor	king	D. Tanta of Baowie	So, madelly	
ם	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)			-	. C. D 1	1 . G :	
Ö	12		Postal Ca				al Servi	<u>se</u>
Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Ma	iden Surname)		
2	Robert Lee Bervine			Judith	n Muse			
_	19a. Informant's Name/Relationship (Type. Prin	t) 19b. Ma	ailing Address (Stree			City or Town, State	e, Zip Code)	
	Warana Baharata / Ghara I		010 014-14					
	Yvonne Roberts/ Step-I		OlO Stirli sposition (Name of	ng Road,		c. Location - City		
	20a. Method of Disposition 12 □ Burial 2 □ Cremation 3 22 □ Removal	from State cemetery, o	crematory or other pla	י ויאועו		c. Location - City	or rown, state	
	4 □ Donation 5 □ Other (Specify)	Plain La	awn Cemete	ry 200	I .	ckewille	New Yo	rk
	21. Signature of Funeral Service Licensee		22. Name and Addr		Funeral	Ueme Inc	- New 10.	-12
	1	and a	500 Unive	rsity Bly	d, W., Si	lver Spr	cing. MD :	2090
	Age Bart Ent the diagram or complications	that assume the death. Do not						
	23a. Part1. Ento the disease, or complications shock, or heart failure. List only one cause	on each line.	enter the mode or dy	ng, such as cardia	or respiratory arrest		Approximate Interval Betw Onset and De	een
	Immediate Cause (Final disease or condition	an len					Onset and Di	Juli
	resulting in death)	ue to (or as a consequence of):					3	
1	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequence of):						
Ę	cause. Enter Underlying Cause (Usecas of injury that initiated events	10 (0) 40 400/1104424/100 47/1						
Examiner								
ŵ	Todaking in dealing Zadi	ue to (or as a consequence of):						
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Į₹	IF FEMALE: 23c. If ye	es, outcome pf pregnancy				23d. Date of	delivery	
jar	in the past 12 months?		3 ☐ Ectopic pregnand 5 ☐ Other (specify)	y		Month	-	ear
sic		Pregnant at time of death Unknown	5 Li Other (specify) _					
Completed by Physician/Medical								
>	Part II. Other significant conditions contributing	to death but not resulting in the	e underlying cause gi	ven in Part I.	23e. Did tobac	cco use contribute	e to the cause of de	ath?
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면					24a. Was an autopsy	prior	autopsy findings a to completion of ca	use of
ő					performe 1 Yes 2 □	d? death ΣNo 1⊟Y		
Be C	25. Was case referred to medical			26. Place of Dea	ath (Check only one)			
8	examiner? 1 Tes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpa	itient 3 DOA Ot	her:	lome 5 ☐ Residence	on 6 MOther /6	Snacify)	
<u>۲</u>		Date of Injury 28b. Time			28d. Describe how		рвопу)	
on	1X Natural 5 Pending	(Month, Day Year) Injur	ry Wo		Zod. Bescribe flow	injury occurred		
äti	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be]Yes 2□No				
ij	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of injury - At home, farm, building, etc. (Specify)	, street, factory, office		28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Numb	er,
è		S (-FW)				,		
2		To the best of my knowledge, de						-
Medical Certification:		the basis of examination and/o manner stated.	or investigation, in my	opinion, death occi	urred at the time, date	e and place, and	due to the cause(s)	
Mec	29b. Signature and title of certifier	1	29c. Licen	se number	294	. Date signed (Me	onth Day Year)	
	255. Signature and the or certifier	1.14						
	- Juoune	san gung		D56691	l t,e	bruary 2	8, 2007	
	30. Name and address of person who complete	d cause of death (Item 23a) (Tvr	pe, Print)					
	Ghousia Sultana, M.D.			irdle. Si	lver Spri	na. Mn o	0906	
	31. Date filed (Month, Day, Year)	32. egistrar's Signature			- vor Spri	g, 1110 Z		
te ar	MAR 0 1 2007	Marie K	Sacreti s					
ar	444.44 0 7 520.	Indiana se la						
101								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 = For State Registrar	State of Marylar		artment of F rtificate of a		Mental Hygien Reg. N	71111	081	63
		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Death	Vone.	3. Time of D	Death
Physici: /Medic		Dorothea Adelin	e Bell				February 2	25, 2007	4:20	a M
Examin		4a. Facility Name (If not institution, gi	ve street and number)	_	4b. City, Town, o	Location of Deati	1 40	c. County of Death	1	
		Holy Cross Rehat	. & Nursing Ce	nter	Burto	nsville		Montgor	nerv	
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth	place (State or intry)	Foreig
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88-1	Director		tgomery		Silver Sr	ring	140.0			
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8 23e	rai	10000 Brunswick A			20910			USA		
Tem Terra	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	o Rican, etc.)	 Race - Amer Black, White 		
0 -	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√ No If Yes, Give Year or Dates:		1 ☐ Yes 2√☐ No	Specify:		Specimhite	9	
Ting in		15. Decedent's 8		16a Dece	ident's Usual Occup	ation	16h	Kind of Business/l	ndueta	
" a	Completed	(Specify only highest g	rade completed)	(Give	kind of work done	durina most of wor	rking	Killid Ol Düsillessyl	ndustry	
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Hygi ther int.	C	17. Father's Name (First, Middle, Las	it)	пат	laresser	18. Mother's Nar	ne (First, Middle, Maide		7 Salon	
ental c ev	00	Francis Cor	nelius Leahy			Maro	uerite Mati	ilda McKr	niaht	
marke umatic	2	19a. Informant's Name/Relationship		19b Maili	ing Address (Street		ural Route Number, City			
th and 17 le trau		Daniel L. Maloney					Rockville, N		<i>p</i> 3335)	
Department of Health and Mental Hygiene. Important: (or Items 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition	·	_	osition (Name of	1		ocation - City or 1	own. State	
nent of I		1 Burial 2 Cremation 3	Hemoval from State		matory or other plac	March	6.			
njury		4 Donation 5 Other (Spec	**	. Mary		ery 200		rgreen Pa	ark, IL	
Depa Impo any ir		21. Signature of Puneral Service Lice	ansee /	F	2.Name and Addre rancis J.	Collins	Funeral Ho	ome Inc.		
		23a. Parti. Enter the disease, or cor	scervo				d, W, Silve	er Spring	Approximate	
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and positive completely filled in by the funeral director, page 2 should be detached for use as the burial-transit property.	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	Quence of).	c Rec	- failu jurgi	tation.			
signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregn 1 Live birth 2 Fete	al death 3	⊒Ectopic pregnancy ⊒ Other (specify)	,		23d. Date of deliment	•	'ear
by tr.	hys	9 🗆 Unknown	9□ Unknown							
pe de	by P	Part II. Other significant conditions	contributing to death but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of de	eath?
should t	ed						1 ☐ Yes 2	2□No 3□Pro	bably 4 DU	nknov
s been 2 shouk	Completed						24a. Was an	24b. Were au	opsy lindings a	vailal
age	E						autopsy performed?	death?	ompletion of ca 2⊠:No	iuse c
iffica or. p	O	25. Was case referred to medical				26 Place of Dec	1 ☐ Yes 2 ☐ N ath (Check only one)	o 1 ☐ Yes	21/2 110	
s cert	0 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatie	nt 3 DOA Oth	00	lome 5 ☐ Residence	6 DOthor (Spec	(64)	
ar thi	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how inju		y)	
th.	5	1 Natural 5 Pending 2 Accident investigation		Injury		k? Yes 2∐No				
s after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		iome, farm, sti	reet, factory, office		28l. Location (Street a City or Town, Stat	and Number or Ru re)	ral Route Numb	∂ <i>97</i> ,
		29a. Certifier 1. Certifying P (Check only one)	Physician: To the best of my known in the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred at the tin	ne, date and place pinion, death occu	o, and due to the cause(s) and manner as nd place, and due	stated. to the cause(s)	
n 24 hours ne Funera sletely fille	Ď	· ·				o oumbor	204 D			
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29b. Signature and title of certifier	N. S.		29c. Licens				. Day, Year)	
within 24 hours To the Funera completely fille	Medi		essi.			4566		26107	. Day, Year)	
within 24 hours To the Funera completely fille	Medi	29b. Signature and title ol certifier	completed cause ol death (Ital	m 23a) (Tvoe	0005	4566	21	26107		
within 24 hours To the Funera completely fille	Medi		o completed cause of death (Item)	m 23a) (Type,	0005	4566	21	26107		

				partment of Health and Nertificate of Death		/ 1111 /	08165	
			Registrar Decedent's Name (First, Middle, Last)	ortinoate or Beatri	2. Date of Death		3 Time on Death	
	Physici /Medic		KEITH ERIC	BUCKALEW	Month 02	19 07	9:40 A. M	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
			WMHS BRADDOCK CAMPUS	CUMBERLAND		ALLEGANY		
2	Funeral Director		5. Social Security Number 218-68-2547 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min	Date of Birth (Month, Day, 1)	Year) Cou	nplace (State or Foreign untry)	
	phone of white light		Usual Residence of Decedent		May	18, 1971 Ma	ryland	
	rylanc how	_	10a. State 10b. County 10c. City, Town o	Location			10d. Inside City Limits	
	ne Ma 8a-f s otifiec	cto	Maryland Allegany Frostbur				1 ☐ Yes 2 🔀 No	
	with the	Funeral Director	10e. Street and Number 20113 National Highway, S.W.	10f. Zip Code		g. Citizen of What Cou	untry?	
	leath ns 23 must	era	11. Marital Status 12. Was Decedent Ever in U.S.	21532- 3. Was Decedent of Hispanic Origin? (Spe		J.S.A. 14. Race - Amer	ican Indian.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify: 	Rican, etc.)	Black, White Specify:	, etc.	
9	2 hou atura cal E	Completed by	15. Decedent's Education 16a. De	cedent's Usual Occupation	16	6b. Kind of Business/I		
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7	ed wil	Con	0 0	disabled		none		
and	l be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last) John Buckalew	18. Mother's Name		aiden Surname)		
Ž	should nd Me mark matic	To		Regina M ailing Address (Street and Number or Rura		City or Town State 7	in Code)	
Š	s 1 and 2. of Health ar item 27 is		Daning Dual-slam		ostburg	Maryland	21532	
ore,	es 1 a of He fitem		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery,			Oc. Location - City or T	own, State	
Baltimore, Maryland 21215-0036	Pag tment tant: I jury o		4 Donation 5 Other (Specify) Finzel Ce	metery Februa	ry 22, 2007 Fi	inzel Ma	aryland	
Bai	permit Depar Impor any In		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Durst Funeral Home, 57 I	Frost Ave., F	rostburg, MD	21532	
6			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac of	r respiratory arres	at,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	hamic lung	d ISAS	2	Onset and Death	
	/Medical Examiner		Due to (or as a consequence of):				/, —	
	# 164	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	cuted od ransit	Examiner	that initiated events C					
Ö,	cate be executed physician and the burial-transit	Ë	resulting in death) Last Due to (or as a consequence of):					
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×6	leath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			004 0-1-44 1		
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ord	w require been sig should b	ted			1 ☐ Yes	2	bably 4 □Unknown	
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Vital			OF Was and referred Africalism			ed? death? 2No 1 ☐ Yes	2 □ No	
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פֿ	ding Phy h. After thi funeral o		27. Many of Death 28a. Date of Injury 28b. Tim	of 28c. Injury at 2	28d. Describe how		<i>TY)</i>	
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Division or	l or Attendater death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,	
_	pital ours eral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place.	and due to the cau	se(s) and manner as	stated.	
	To the Hospita within 24 hours To the Funeral completely filler	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o	investigation, in my opinion, death occurr	ed at the time, date	e and place, and due	to the cause(s)	
	To the within 2 To the comple	Ž	29b. Signature and title of confign	29c. License number	290	I. Date signed (Month,	Day, Year)	
	5/1		► / JULIGON (M)	D22181	FC	BRUARY /	92007	
	nas		30. Name and address of person who completed cause of death (Item 23a) (Type Gary Wagoner m.b. 925 B	e, Print) ISHOP Walsh Rock	al alinah	my laine	1 01500	
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature		J. Cume	enand, m	U OIDUA	
	Registr		FEB 2 1 2007 June 25 /2	carle				

			For State	State of Ma	ryland		artment of F r <i>tificate of</i>						00166
			Registrar 1. Decedent's Name (First, Middle, Las	t)			timoato or	Dean		. Date of Dea		111	3. Time of Death
į.	Physici /Medic		Rose U. Cantor						Fe	Month ebruary	^{Day} 25, 2	007	8:45 P M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location	of Death		4c. Count	y of Death	
	Funeral Director		Rockville Nursin 5. Social Security Number 072-01-9499 6. Security Number		(In yrs. la.	st birthday) Yrs.	Rock If Under 1 Year Months Days	If Unde Hours	Min. 8	Date of Birth (Month, Day Sept 9	n , Year)	Cour	place (State or Foreign
	pu >		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation			-	,		0d. Inside City Limits
	Maryla f shovied at	or											1 ☐ Yes 2 X No
	r 28a-	Director	Maryland Montgo	nery	S11	ver S	pring 10f. Zip Code			1	log. Citizen of	What Cour	ntry?
	tth wit 23a o ust be		708 Bonifant St				2091	0			US	A	
36	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub: 1 ☐ Yes 2X No	lispanic O an, Mexic Specify		fy Yes or No- can, etc.)	14. Ra Bla Speci	ce - Americack, White,	etc.
215-0036	2 hou natura ical E		15. Decedent's Ed	ucation	Ţ	16a. Dece	dent's Usual Occup	ation		- 1	16b. Kind of E		ite dustry
7	ithin 7 ne. nan "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	-)		kind of work done DO NOT use retired		st of working	1		_	
12.5	filed within Hygiene. ther than "	S	17. Father's Name (<i>First, Middle, Last</i>)			Camp	Directo		her's Name /		Recreat Maiden Surna		Day Camp
Maryland 2	Mental Mental Marked of	To Be	Harry_Uslan_							lda Kal		me)	
ary	S E E	-	19a. Informant's Name/Relationship (7	ype. Print)	T	19b. Mailir	ng Address (Street					, State, Zip	Code)
	and 2 ealth a m 27 is		Ken Cantor/Son		,		Bonifant	St,					
Baltimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ce of Dispo netery, crei	sition (Name of matory or other plac	ce)	Date	е	20c. Location	- City or To	own, State
	permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify 21. Signature of Euneral Service Licen		Shar		rdens 2. Name and Addre				Vahal		
n	Depti Impo		1 Strap	~		1							ноте , MD 20904
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused to one cause on each line	the death.	Do not ent		ng, such a	s cardiac or r	espiratory arr		r	Approximate Interval Between Onset and Death
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O. BOX 6	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	2 ☐ Fetal d	leath 3	Ectopic pregnancy	/			j.	ate of delive	ery Day Year
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ras	requires that een signed b nould be deta	ed by								1 🗆 Y	es 2∐XNo	3 ☐ Prot	ably 4 Unknown
I Records,	The la ate has page 2	Completed								24a. Was a autops perfor 1□ Yes	sy	prior to co death?	psy findings available mpletion of cause of 2 No
VITAII H	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Liansitat.			lou.		ce of Death (0	Check only or			
0	Phys this al dir	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatien: 28a. Date of Injury		R/Outpatier		41.41			ence 6 Ot		y)
	nding th. : After	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	Wor	k?¨ Yes 2[a. Describe in	ow injury occu	ileu	
DIVISION	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury building, etc.		e, farm, str	eet, factory, office		28f	Location (S City or Town	treet and Num n, State)	ber or Rura	nl Route Number,
	he Hospit in 24 hour he Funera pletely fille	Medical (29a. Certifier (Check only one) 1X Certifying Phyone) 2 Medical Example 1 Medical	ysician: To the best of liner: On the basis of e and manner state	examinatio	edge, deatl n and/or in	n occurred at the til vestigation, in my o	me, date a	and place, and eath occurred	d due to the o	ause(s) and material	anner as s , and due to	tated. the cause(s)
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	12	i	Tool				Doc	64	118		2-2	2-9	(00)
			30. Name and address of person who o		,	, , , , ,		01.	оду М	2083	2		
Ì	Sta Registr		Mina Fazli, MD 31. Date filed (Month, Day, Year) MAR 0 1 200		ce Pr		DI, #101	, 011	пеу, гп	<u>, 2003</u> ,	<u> </u>		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) .H4 ea Day O **Physician** 200 tebruary **JOSEPH** LEE CANTLER /Medical 4b. City, Town, or Location of Death 4. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F Yrs. 9, 1942 MARÝLAND 213-40-9487 64 NOV. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director KEEDYSVILLE MARYLAND WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21756 4127 TREGO MOUNTAIN ROAD U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is 1 and 2 should be filed within file Health and Mental Hygiene. College (1-4or 5+) CLEANING COMPANY OWNER & OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNIE ELIZABETH THOMPSON DELMORE CHARLES CANTLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4127 TREGO MOUNTAIN ROAD, KEEDYSVILLE, MD CAROL E. CANTLER/SPOUSE permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVEN MEM GARDEN: 3/02/2007 FREDERICK, MARYLAND 5 ☐ Other (Specify) 22. Name and Address of Facility 7606 Old National Pike 21. Signature of BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine signed by the attending physician and the detached for use as the burial-transit resulting in death) Last Due to for as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 24 hours after death. 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / / filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated

25H7

HImed 31. Date filed (Month, Day, Year) 5

29b. Signature and title of certifier

Oak Hill 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12821

HUE.

29c. License number

60228

Hagers town

29d. Date signed (Month, Day, Year)

Maryland 21742

Feb 27 2007

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **ALMA FLORA** CONNOR 02 2007 2200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F 217-14-4902-A 89 03/06/1917 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Paca Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey Earl Miller Bertha Sophia Barnhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George F. Connor / son 1535 Sappington Drive, Gambrills, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Restlawn Mem. Gardens 03/03/2007 ∕5 ☐ Other (Specify) LaVale, MD 4 ☐ Donation 22. Name and Address of Facility Adams Family Funeral Tome, F.A. 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Syndrome SIS 2 days. Due to (or s a consequence of):

/Medical Examiner certificate be executed burial-trar Division or Vital Records, P.O. Box 68760 attending physician use the

Examiner Physician/Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

12 should be filed w h and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important; If Item 27 is marked oth any injury or other traumatic event

Physician

Completed by Be Certification: To

After this To the Hospital or Attending death. within 24 hours after death To the Funeral Director: filled in by the 5

nd

29b. Signature and title of certifier

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State Registrar

dical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect					
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Complet					24a. Was an autopsy performed? 1 Yes 2 No	death?	sy findings available pletion of cause of
Be	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)		
To	1 ☐ Yes 2 ☑ No	Hospital: 1X Inpatient 2]ER/Outpatient 3 ☐ [OOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)	
	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur		
Medical Certification:	3 Suicide 6 Could not by 4 Homicide determined		ome, farm, street, factory)	ory, office	28f. Location (Street an City or Town, State	nd Number or Rural I	Route Number,
edical (29a. Certifier (Check only one)	nysícian: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause(s) curred at the time, date and) and manner as stated d place, and due to t	ted. he cause(s)
ž	29b. Signature and title of certifier		2	9c. License number	29d Dat	te signed (Month Da	av Yearl

29c. License number

00055325

Frostburg MD21532

29d. Date signed (Month, Day, Year)

Feb 28, 2007

Terrace

MD

32. Registrar's Signature

48 Tarn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHIN

MD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** 05:45 PM Amy Griffith Crook February 26, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Locetion of Death 4c. County of Death Examiner Union Hospital of Cecil County E1kton
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 200 Yrs Director 218-46-4266 Sept. 26, 1945 Maryland Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic svent, the Madical Examinar must be notified at Delaware Sussex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 50 Lakewood Drive 19958 United States by Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Pages 1 and 2 should be William G. Jack V Lora Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traignes. Harvey R. Jack / Brother 863 Turkey Point Road, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 28, 2007 Mayerdale Crematory Newark, Delaware 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Cirhosi's **Physician** unknown /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physicien and dedeached for use as the burial-transit The law requires that the death certificate be executed 208 Due to (or as a consequence of) Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the linector, page 2 s 2 No 1∏ Yes of Vital iours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? To Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō within 24 hours a
To the Funeral I
completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier z immedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0026183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madhu Sachder, M.D. 322 E Cecil Ave. North EAST md 21901 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				epartment of Health and M	lental Hygie	ne	
			-3	Certificate of Death	Reg.	No.2007	08170
8	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Wilford Councill Chase	1	Februar		11:40 AM
	Examir	ner	4a. Facility Name (If not institution, give street and number) Berlin Nursing Home	4b. City, Town, or Location of Death Berlin		4c. County of Death Worceste	70
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthola	ace (State or Foreign
į.	Director		212-44-6366 1™ 2□F 63 Yrs	s. Months Days Hours Min.	(Month, Day, Ye 12 16 1	ear) (Count	ry)
ì	pu ,		Usual Residence of Decedent				
	aryla shov	<u> </u>	10a. State 10b. County 10c. City, Town of	r Location		10	od. Inside City Limits 1 √ Yes 2 No
	the M	Director	MD Worcester Ocean 10e. Street and Number		140		
	with taor			10f. Zip Code	10g.	Citizen of What Count	.y :
	ms 2;	Funeral	9004 West Biscayne DR 11. Marital Status 12. Was Decedent Ever in U.S.	21842 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - America	n Indian,
٥	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married 1 Yes 2 No		Rićan, etc.)	Black, White, e	tc.
2-0036	ours ours	d by	3 ☐ Widowed 4 ♣ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
7	"natu	Completed	15. Decedent's Education 16a. Do (Specify only highest grade completed) (G	ecedent's Usual Occupation Give kind of work done during most of worki fe. DO NOT use retired)	ng 16b	. Kind of Business/Inde	ıstry
7	within iene. than "	E D	Elementary/Secondary (0-12) College (1-4or 5+)	computer Consultant		C	
O V	filed Hygid ther snt, th	ပ္သ	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	Computers	
a	id be ental ked c	To Be	Thomas C. Chase, Jr.		ouncill Ch	,	
ary	2 should be and Menta is marked raumatic ev	-	\	lailing Address (Street and Number or Rura			Code)
Ž	1 and 2 Health a em 27 is		Laura Chase Conner (daughter) 8	Crescent DR, Mounta	in Lakes,	NJ 07046	
o G			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition Cermetery,	isposition (Name of crematory or other place)	Date 200	Location - City or Tow	n, State
Ε	Pages ment of tant: If its lury or o		4□Donation 5□Other (Specify) Cape He	enlopen Crem. 2/28/	2007 Fr	ankford, D	E
paltil	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility The 108 William ST, Ber	Burbage	Funeral Ho	me
	96		23a Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on schools.				Approximate
	Physician	8 1	Immediate Cause (Final	/			Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due tr (or as a consequence of):	Lymphoina			(eurs
	Examiner		Cognosticilly list conditions	(5) Ø			
	p _i	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying				
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C				
S S	ficate be executed physician and is the burial-transit		bue to (or as a consequence of).				
00/00	ficate phys the	edical	d				
X O O			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	-5-		23d. Date of deliver	v
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5	at the by th tache	hys	9 ☐ Unknown				
'n	es tha igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	cause of death?
ecords,	requi	ted			1 Tyes	2 No 3 Proba	bly 4 Unknown
ני	e law has b ie 2 sl	Completed			24a. Was an autopsy	prior to com	sy findings available pletion of cause of
פ	r: Th icate r, pag				performed 1 Yes 2 ☐	? death? 1 ☐ Yes 2	!□ No
5	siclal certi irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → Ne	26. Place of Death			
5	g Phy er this eral d	$\vdash v$	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	ne 5 ∐ Residence 28d. Describe how in	e 6 Other (Specify)	
5	ath. rr: Aft	atio	1 (Month, Day Year) Inju 2 Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No			
2	r Atte er der irecto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Si	and Number or Rural	Route Number,
ב	urs aft ral Di					,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to the property of the funeral director, page 2 to the funeral director.	Medical	29a. Certifier (Check only one) 2□ Medical Examiner: On the best of my knowledge, do (Check only one) 2□ Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, a or investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
	To the vithin To the complete	Me	29b. Signature and title of countier	29c. License number	29d.	Date signed (Month, D.	ay, Year)
			M/ 1) Heale and	かつスクムき	7	2/28/	C.C.
•	, ,	4	30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)		10	-/-
8	AA		Mille (as Boodelei, up 12	09 Coursel logle	> le	wick 4sl	and De 19944
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 2007 32. Fugistrar's Signature	Short	1		,
	- region		MINU A T COOL TOWN				

		•	1 - For State Registrar	State of	f Maryla			t of He	ealth and M eath		Reg. No.	07	08171
	Physici	20	1. Decedent's Name (First, Middle, Last							2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Kathlee			way				Februa	+	007	9:30 A M
	Examin	er	4a. Facility Name (If not institution, give						ocation of Death		4c. County	_	
			6150 Foreland Gar 5. Social Security Number 6. Se			s. last birthday)		umbia	If Under 24 Hrs.	8. Date of Bir	Howa:		place (State or Foreign
4.	Funeral Director				98	Yrs.	Months	Days	Hours Min.	8. Date of Bir (Month, Da	19, Year) 15,1908	Cour	place (State or Foreign ntry)
			Usual Residence of Decedent							oury .	2,1200		
	how		10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	Od. Inside City Limits
	a-f-	cto	MD Howard		C	olumbia	ì						1 ☐ Yes 2 ☐No
	or 26	Director	10e. Street and Number				10f. Zip				10g. Citizen of V	Vhat Cour	ntry?
	ath w		6150 Foreland Gar					1045	. 0:::0::0		United		ates can Indian,
36	hours after death with the Maryland tural; or Itams 23a or 28a-f ahow at Exercitive frings be rediffed at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Yes If Yes, Giv	rces? 2 X No e	1	Was Dece fYes, spe 1 ☐ Yes	cify Cuban,	panic Origin? (Sp. , Mexican, Puerto Specify:	ecry Yes or No Rican, etc.)		k, White,	etc.
21215-0036	72 hours natural', ilcal Exe		15. Decedent's Edu	Year or Da	1(85.	16a. Dece	dent's Usu	al Occupati	ion		16b. Kind of Bu	Whj siness/in	
5	S 3	Completed	(Specify only highest grad	e com <i>pleted)</i>	4 5.)	(Give	kind of wo	ork done du ise retired)	ring most of work	ing			•
212	W C C	E O	Elementary/Secondary (0-12)	College (1	-40r 5+)	Lik	rari	an			Federa.	L Gov	verment
	othe oth	0	17. Father's Name (First, Middle, Last)						8. Mother's Nam	e (First, Middle	, Maiden Sumam	(e)	
<u>a</u>	should be nd Mental marked o	To B	William F. Skelley	7				1	Anna Mar	ie Gilr	oy		
Maryland	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (T)			19b. Mailir	ng Address	s (Street an	d Number or Run	al Route Numb	er, City or Town,	State, Zip	Code)
	1 and 2 Health tem 27		Ellene C. Barnes/I	aughte							, MD 210		
ore			20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐I	Removal from	State 20b.	Place of Dispo cemetery, crei	natory or o	me of other place))	Date	20c. Location -	City or To	own, State
Ë	Pages ment of I ant: If Its jury or o		*4 □Donation 5 □ Other (Specify,		M	Company of the company			ery 3-3-		Elkridge		
Baltimore,	permit. Page Department Important: If any injury or snce.		21. Signature of Funeral Service Licens	- Note	M01								ly FH Inc. MD 21043
	a l		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that c ne cause on e	aused the de ach line.						rrest,		Approximate Interval Between
	Physician	1	tmmediate Cause (Final disease or condition	Con	gest	ul P	lai	THO	relus			- 1	Onset and Death
4	/Medical Examiner		resulting in death)	Due to (on s a conse	equence of):							
В	Cxammer		Sequentially list conditions, if any, leading to immediate	b		A)						_	
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Вох	The law requires that the death certifue has been signed by the attending to age 2 should be detached for use as	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			-				23d. Dai	e of deliv	ery
	death e atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ♣ No	4□Pregn	irth 2□Fe ant at time of]Ectopic p] Other <i>(s)</i>				Мо	nth	Day Year
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٦,	es tha igned be det	by P	Part It. Other significant conditions co	ntributing to de	eath but not re	esulting in the u	nderlying	cause given	in Part I.				he cause of death?
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Vital Records,	law requas been 2 shoul	Completed								24a. Was	an 24b.	Were auto	opsy findings available impletion of cause of
ž	The I	E O								perf	ormed?	death?	2 ½ No
ita	ilan: T	Be (25. Was case referred to medical examiner?						26. Place of Deat	h (Check only	one)		
of V	Physician: this certific ral director,	2	1 □ Yes 2 □ No	Hospital: 1 □ I	npatient 2	☐ ER/Outpatier	nt 3 D	OA Other	4 Nursing no		idence 6 Oth		(y)
<u>_</u>		ou:	27. Manner of Death 1 Alatural 5 ☐ Pending	28a. Date (Mont	of Injury th, Day Year)	28b. Time o tnjury		28c. Injury a Work?	,	28d. Describe	how injury occur	red	
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Division	l or Atten after deatl Director: 3 in by the	Certification:	4 Homicide determined	28e. Place buildi	of Injury - At ng, etc. <i>(Spe</i>	home, tarm, str cify)	eet, factor	y, office			(Street and Numb wn, State)	er or Hur	ai Houte Number,
	urs a			To the	h			4 - 4 4 1 - 4 1		and due to the			tatad
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ner: On the b	asis of examination of the state of the stat	nation and/or in	n occurred vestigation	n, in my opi	nion, death occur	red at the time	date and place,	and due t	o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and main	TOT Stated.		29	c. License	number		29d. Date signe	d (Month,	Day, Year)
	F ₹F 8		Granon 1ª	nun	OM	0	1	000	9526		March 1	20	07
	-		30. Name and address of person who d	ompleted caus	e of death (It	em 23a) (Tvne						, 20	07
الماريخ	~		FRANCIS BRUNO		Med	ical 1	ARTS	Bui	Iding,	Colur	nbia.	MD	21044
	Sta	ite	31. Date tiled (Month, Day, Year)	32. F	gistrar's Sig	nature			- 41				
	Registr		MAR 0 2 2	007	Lese	N. 1	ment						

07-01519 William Duck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Amended # 2 Reg. No 2. Date of Death Physician/ 3. Time of Death 2007 Month Day 2006 February 24, 2006 WILLIAM DUCK IV Medical Examiner 0225 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Shock Trauma Baltimore University Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months Min Director 06-29-1985 1 X M 2 F 228-37-2563 Country) VA 21 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits MD BALTIMORE 1 X Yes 2 No 28a-f shov or items 23a or 28a-f sho must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3306 W. FOREST PARK AVENUE 21216 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 Armed Forces? White, etc. Married 2 X No Yes within 72 hours after Yes 2 X No specify Specify: BLACK 3 Widowed Divorced If Yes, Give Year other traumatic event, the Medical Examiner \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) t Pages 1 and 2 should be filed within 72 hr ment of Health and Mental Hygiene. That I fliem 27 is marked out in other re-Elementary/Secondary (0-12) 12th STUDENT EDUCATION 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) WILLIAM DUCK III PATRICIA PEGRAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type, Print) PATRICIA CHASE - MOTHER 3306 W. FOREST PARK AVE. BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MD NATIONAL PARK 03-02-07 LAUREL, MARYLAND Donation 5 Other Specify permit Departn 22. Name and Address of TAYLOR, 21. Signature of Funeral Service Licens II FUNERAL HOME W NORTH AVENUE BALTIMORE MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Weetlew) Death a Multiple stab wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last nd /sician/Medical X AMENDED #4a, perME, g865,3/15/07 TT burial -UNPENDED attending physician for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the at the detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P.O. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? ✓ Yes 2 No 2 No 1 🗸 Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient Other₄ this ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 28a. Date of Injury (Month, Day Year) Feb 24, 2007 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Subject stabbed Natural 1 Yes 2 ✔ No Director: d in by the f 5 Pending Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)
200 South Fulton Avenue, Baltimore, MD Certif (Specify) Local Street Funeral 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. February 24, 2007 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Theodore M. King, Jr., MD.

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

07-01558 Raul Alfredo Duran

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		l-For State Registrar		Certific	ate of Deat	th	F	Reg. No.	1 00110
Physicia Madical Exercis	n/	Decedent's Name (First, Middle)					2. Date of De Month		3. Time of Death 0915 hrs
Medical Examir	ier -	Rau1 A1f 4a. Facility Name (if not institution	redo Dura	n	4h City	Town, or Location of	Month February	25, 2007 4c. County of De	
- ·		4001 Oglethorpe Stree				tsville	or Dealit	Prince Geo	
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs last bir	thday) If Und	ler 1 Year If Unde	er 24Hrs. 8 Date of B	irth(MM/DD/YYYY) 9.	
Director		none	1XM 2F	29	Yrs. Month	ns Days Hours	Min. Feb.	3, 1978 For	Courtry Salvador
	Ė	Usual Residence of Decedent						3, 2,,,,	
w any		10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1 X Yes 2 No
·land -f sho	į.		e Georges	Hyat	tsville				
Man or 28a	Director	10e. Street and Number 4001 Oglethor	pe Street		10f. Zip	.0782		10g. Citizen of What C E1 Salva	
ith the	릵	11. Marital Status	12. Was Decedent I	Ever in II S			gin? (Specify Yes or N		nerican Indian, Black,
eath w items	uneral	1 X Never Married 2 Ma	arried Armed Forces?	X No			Puerto Rican, etc.)	White, etc	
fter d	뜨	3 Widowed 4 Dive	orced If Yes, Give Year or Dates:	A No	1X Yes 2	No specify:	SalVadoran	Specify: W	hite
ours a	ğ þ	15. Decedent's Education (Spec		pleted) 16a.		Occupation (Give		16b. Kind of Busine	ss/Industry
n 72 h	Sete	Elementary/Secondary (0-12) 6th	College (1-4 or 5	+)	Painter	•	aso rouled)	Constr	uction
withi withingiene.	Completed	17. Father's Name (First, Middle,	Lact)		rainter		's Name (First, Middle,	Maiden Surname)	
e filed all Hyster or the	BeC	Alfredo Antoni					yna Catali		
MD 21215-0036 Id 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. In 27 is marked other than "natural", or items 23a or 28a-f she anmatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationsh						mber, City or Town, St	
MD d 2 sho tth and n 27 is		Reyna Catalin	a Duran (Mot)	<i>'</i>	_	ethorpe :		tsville, Mo	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta		of Disposition (Na tory or other place		Date	20c. Location - City	FI Collegedok
imo Page nent c		4 Donation 5 Other Sp	pecify:	Fam	ily Ceme	tery	ar. 0, 200	ov san Migo	ie1,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within . Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		21. Signature of Funeral Service	Licensee D 6.4	117		Address of Facility		Tnc	
Physician		23a. Part I. Enter the disease, or	complications that caused	ne death Doin	ot enter the mode	of dving, such as o	ardiac or respiratory a	NW Washir	ngton DC 2001 Approximate Interval
/Medical	ļ	failure. List only one cause	on each line.				,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hanging Due to (or as a conse	quence of):					
ν.		Sequentially list conditions,	b						
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):					
	Examiner	(Cissess or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					-
ecuted and trans			d				· · · · · · · · · · · · · · · · · · ·		
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED						
3760, ficate b g physic	-	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcom			3 Ectopi	c pregnancy	23d. Date of deli	very Day Year
Box 687 e death certifine the attending ed for use as t	<u>icial</u>	past 12 months?	4 Pregnant at	Carrie of decade	5 Other (Spe		o programay		/
Bo e deat the at ed for	Physician	1 Yes 2 No 9 Unk	9 Unknown						
P.O. es that the igned by	b P	Part II. Other significant conditi	ons contributing to death	but not resultir	ng in the underlyin	g cause given in Pa			e to the cause of death? Probably 4 Unknown
cords, P.O. Box 68. law requires that the death certifi has been signed by the attending		· —							autopsy findings available
ord aw rec as bee	Completed						auto	1 .	to completion of cause of
Re The page	50						1 🗸 Yes	2 No 1 🗸	
tal ician: certif	Be	25. Was case referred to medical examiner?	Hospital:			26 Place of Death	`	Residence 6 🗸 0	ther Seene
Division of Vital Records, tal or Attending Physician: The law requirents after death. "A Director: After this certificate has been signed in by the funeral director, page 2 should be	P	1 Yes 2 No	28a Date of Inju	ry 28h	Outpatient 3 1	DOA Other 4 28c. Injury at Work	Nursing Home 5 28d Describe	how injury occurred	mer. Scene
nding th.	ioi	1 Natural 5 Pend	found: Day'Yo	FO	UND:	1 Yes 2	 ISubject ha 	nged himself	
isior Attender death	icat	2 Accident Inves	stigation Feb 25, 2007		50 hrs farm, street, factor	y, office building, e			Rural Route Number, City
Div ital or ral Di	Certification:		d not be (Specify) Sin	gle Family			or Town, 4001 Ogleth	State) orpe Street, Hyattsv	rille, MD
Division of Vital F Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi- tedy filled in by the funeral director,	aC	29a Certifier 1 Certifying Pl	hysician: To the best of my	/ knowledge, de	eath occurred at th	e time, date and pl	ace, and due to the ca	use(s) and manner as	stated.
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	one) 2 Medical Exam	miner: On the basis of exar and manner stated	nination and/or	investigation, in m	ny opinion, death o	ccurred at the time, dat		
F 3 F 3	ž	29b Signature and title of certifie			29	c. License number		29d. Date signed (
3		my hu	, m.D			O.C.M.E.		February 26, 2	2007
84		30. Name and address of person	·			imore, MD 212	201		
			nt Medical Examiner	's Signature	Oneer, Dall	OIG, WID Z IZ			
St Regist	ate trar	MAR 0 2 2007 Year)	Bound.	South	9				

ORIGINAL

			For State Registrar			State) IVIC	ıryıarı			icate of		na ivi	entai Hy	rgierie Reg. No	201	07	0.81	75
	Physici	an	1. Decedent's Nam		le, Last))				-	,		1	2. Date of D	Da	ay a	Year	3. Time of	_
	/Medic	cal	4a. Facility Name (Freda	n aive s	street and n	Ma	.у			lan . City, Town, c	or Location of		tebru		17, 2 c. County	2007 of Death	111:10	PM
	Examir	ier	Lions C					Ext.	Car		-	rland	Douti				llega	ıny	
	Funeral Director		5. Social Security N	183	6. Sex	x]M 2∏[F		e (In yrs. i	last birthd Yrs	M	Under 1 Year onths Days		4 Hrs. Min.	8. Date of B (Month, D 06 / 12	ay, Year			lace (State on try)	r Foreign
	land ow t		Usual Residence of 10a. State	10b. County	,			10c. City	y, Town o	r Locatio	on						1	0d. Inside Cit	ty Limits
	Mary a-f she ified a	tor	MD	Alle	egan	ıy			Cur	mber	land							1 ▼ Yes	2∐No
	th with the 23a or 28a ast be noti	al Director	10e. Street and Nu 17	umber 01 Bedi	ford	Stree	et			1	0f. Zip Code	215	502		10g. Ci	itizen of W US		ntry?	
√ 036	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status 1		rried	12. Was Dec Armed F 1 ☐ Yes If Yes, G Year or I	orces? 2 📉 N ive		S. 1		Decedent of I s, specify Cub Yes 2 No		in? (Spec Puerto F	cify Yes or N Rican, etc.)	10-		k, White,	an Indian, etc. White	
ا م	"natu	etec	(Spe	15. Deceder cify only highe	nt's Edu est grad	cation e completed)	Į,	16a. De	ecedent	s Usual Occup of work done NOT use retire	pation during most	of workin	g	16b. h	Kind of Bu	isiness/Ind	dustry	
da	within lene. than he Me	Be Completed	Elementary/Sec	ondary (0-12)		College	(1-4or 5	+)	""		memake					Home	Э		
7	be filed tal Hygi d other event, t	Š	17. Father's Name		, Last)									(First, Middl		n Surnam	_		
<u> </u>	Menta Menta arked atic ev	To E	Clevel	and 		Wil	llia	m		igfi		Lula			ane ———		Buc		
n, Freda M	and 2 sho ealth and n 27 is ma		Joan K.	Cosgro			nter		84	E1e	ddress <i>(Street</i> anor S	Street,	LaV	ale,	Mary.	land	215	02	
Dolar Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. I filmportant: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			□Cremation 5 □ Other (Specify)		State			Mem 22. Na	n (Name of ory or other pla orial l arme and Addre Decati	Park 0 ess of Facility	2/21 Ada	ms Fan	Cully		land ral	, MD	Р.А.
68760	Attending Physician: The law requires that the death certificate be executed refeath. The law requires that the death certificate be executed by the attending physician and an only the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	23a. Part f. Enter shock, or he Immediate Cause disease or conditive sulting in death) Sequentially list or if any, leading to icause. Enter Und Cause (Disease o that initiated event resulting in death)	(Final on on on on on on on on on on on on on	or complete only of	Due to	(or as	a consequa	th. Do not the Do	e	Head		eardiac of		arrest,			Approximate Interval Beth Onset and I	e ween Ceath WHIS
Division or Vital Becords. P.O. Box	w requires that the death certi	by Physician/Me	IF FEMALE: 23b. Was deceded in the past 12 1 ☐ Yes 2 9 ☐ Unknow	2 months?	2		birth gnant at	pf pregna 2 ∐ Feta time of d	I death		opic pregnanc her (specify) _	су				23d. Dat Mo	e of delive	-	Year
<u>a</u>	ss that gned b	oy Pt	Part II. Other sign						1		lying cause gi	ven in Part I.		23e. Did	l tobacco			ne cause of d	
pro	require een si	ted		Adva	mer	eel	<u> </u>	eme	ntra	2_				1	Yes 2	2 □ No	3 ☐ Prob	pably 4 All	Jnknown
al Reco	ician: The law rector, page 2 sh	Completed									- 			24a. Wa aut per 1∐ Yes	opsy formed?		Were auto prior to co death? I □ Yes	psy findings ampletion of ca	available ause of
Ĭ.	sician certifi irector	Be	25. Was case reference examiner? 1 ☐ Yes 2 ∑	erred to medica No	100	Hospital: , _	Innatia	m+ 2 🗆	ER/Outpa	tiont	Oti			(Check only		a □0:			-
Jo Cr	ing Phy: After this uneral di	on: To	27. Manner of Dea	ath 5 □ Pendi	ing	28a. Date	Inpatie of Inju onth, Day	ry	28b. Tim Inju	ne of ry	28c. Inju Wo	ury at ork?	2	ne 5 Resemble				<i>y)</i>	
ivisio	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could	tigation I not be mined	28e. Plac	e of injuding, etc	ury - At ho c. (Specif	ome, farm <i>y)</i>		M 1 ☐ 1 ☐ factory, office]Yes 2∏N	-		(Street a		er or Rura	al Route Num	ıber,
	Hospital or 24 hours afte Funeral Din tely filled in		29a. Certifier (Check only one)			iner: On the	basis of	examina			curred at the t								÷)
	To the within 2. To the complet	Medical	29b. Signature an	d title of certifi	er	and ma	inier Sta	neu.			29c. Licen	se number			29d. D	ate signed	d (Month,	Day, Year)	
	2000		> w	onsoc	kel	h	MI	D .			1#1)55	32	5	Febr	ruar	1121	ומב כ	7
			30, Name and add	iress of person	n who co	ompleted car		eath (Item	n 23a) (Ty	pe, Prir	t)		-	Lh. v	7	IAK	7	1675	1
		ate	31. Date filed (Mo		0 20	32.		ar's Signa	ture	A	LYAC		Y U S	<u> </u>	yi i	N(12	2	123.	
	Regist	rair	E C	LD W	V LU	01 /		20 0	es.	1. 10.3	Se Colored								

		i	For State Registrar	State of Ma		artment of Health ertificate of Death		ygiene Reg. No. 200	7 08176
	Physicia /Medic	3	1. Decedent's Name (First, Middle David		yne	Dennison	2. Date of D Month FEBRUA		3. Time of Death 19:27 M
	Examin		4a. Facility Name (If not institution MEMORIAL HOSPI)			4b. City, Town, or Location CUMBERLAND	of Death	4c. County of D	
1	Funeral Director		5. Social Security Number 212-84-6939	6. Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. last birthday 37 Yrs.	Months Days Hours	Min. 8. Date of B (Month, D 06/20		Birthplace <i>(St</i> ate or Foreign Country) aryland
	yland low at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	ne Mar 8a-f sh otified	Director		egany		Cumberland		10 000 000	1 X Yes 2 □ No
	th with the	al Dire	10e. Street and Number 20 Detroit	Drive		10f. Zip Code 21502		10g. Citizen of What USA	Country?
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 12	Ever in U.S. 13	. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☒ No Specify		lo- 14. Race - A Black, V Specify:	merican Indian, /hite, etc. White
Baltimore, Maryland 21215-0036	filed within 72 hou I Hygiene. other than "natura ent, the Medical E	To Be Completed by	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12	t's Education st grade completed) College (1-4or 5	Giv (Giv life.	edent's Usual Occupation e kind of work done during mo DO NOT use retired) Taxi Driver	est of working	16b. Kind of Busine	ess/Industry
9	il Hygie other i	Se Co	17. Father's Name (First, Middle,	Last)			ner's Name <i>(First, Middi</i>		or tation
ylar	should be tand Mental some marked or umatic ever	To E	William	Р.		on, Sr.	Shelbea	J.	Cox
Mar	and 2 sh salth and n 27 Is m		19a. Informant's Name/Relations William P. Der			ling Address <i>(Street and Numb</i> O Detroit Driv			^{re, Zip Code)} 1502
nore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other trong once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5			position (Name of ematory or other place)	Date 02/24/2007	20c. Location - City Cumberla	
Baltii	permit. F Departm Importar any injur		21. Signatur uneral Service			22. Name and Address of Faci 404 Decatur S	ility Adams Far	nily Funera	al Home, P.A.
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. CARDIAO Due to (or as b. SEVERE	C ARRHYTHM a consequence of):			arrest,	Approximate Interval Between Onset and Death
	ecuted ind transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	U		ATORY SYNDROM	E		
68760,	ficate be executed physician and is the burial-transit	edical Ex	resulting in death, East	,	a consequence of): E RETROPER	ITONEAL HEMAT	COMA A	1 for	F 2 (, 2007
.O. Box 6	that the death certific led by the attending pi detached for use as f	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	V	23d. Date of Month	delivery Day Year
<u>α</u>	es pegi	by	Part II. Other significant condit	ons contributing to death b	ut not resulting in the	underlying cause given in Part			e to the cause of death? Probably 4 X Unknown
Il Records,	The law ate has b page 2 st	Completed						topsy prior rformed? deat	
Vital	Physician: This certificateral director, p.	Be	25. Was case referred to medical examiner? Release	Hospital: Inpatie	ent 2 ☐ ER/Outpati	Other	ce of Death <i>(Check only</i> Nursing Home 5 ☐ Re	,	Proceife d
Division or	tending eath. tor: After the fune	Certification: To	27. Manner of Death 1 □ Natural 5 □ Pendi	28a. Date of Inju (Month, Da gation not be nined 28e. Place of injuilding, et	28b. Time Injury 2007 1330 (sury - At home, farm, str. (Specify)	of 28c. Injury at Work? P M 1 X Yes 2	28d. Describe Taxi C taxi (28f. Location City or T	e how injury occurred ab driver Motor vehi (Street and Number o own, State)	was driving cle crash)
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)		of my knowledge, de of examination and/or	ath occurred at the time, date a investigation, in my opinion, do			the second secon
	To the within 2 To the complet	Me	29b. Signature and title of ertifi	<i></i>		29c. License number		29d. Date signed (N	fonth, Day, Year)
•	İ		30. Name and address of person	who completed cause of o	death (Item 23a) (Type	D23167	7	FEBRUARY	20TH, 2007
	nes		ARRISUENO, JUA	N A., M.D.,	902 SETON		205, CUMBER	LAND, MD 2	1502
	Sta Regist		31. Date filed (Month, Day, Year FEB 2 2	2007 32 Registr	rar's Signature	hade			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:40 AM FEBRUARY 27, 2007 CHARLES LEONARD DOUGAREE, JR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 65 SEPTEMBER 19,1941 MARYLAND Director 220-38-6689 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Exaπiner must be notified at 1 □Yes 2 No Director MARYLAND | QUEEN ANNE'S CHESTER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 PILOT COURT 21619 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INDUSTRIAL 12 MACHINIST permit. Pages 1 and 2 should be filed obpartment of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES L. DOUGAREE, SR AUDREY **MCGUIGAN** 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BETTY LOUISE DOUGAREE/WIFE 100 PILOT COURT, CHESTER, MARYLAND 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MARCH 1 1 ☐ Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 2007 STEVENSVILLE, MARYLAND 21. Signature of Furieral Service Licenses FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one is use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a correquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day õ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 212/No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 ☐ Impatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 1 Natural 5 ☐ Pending investigation M 1 □ Yes 2 □ No 2 Accident within 24 hours after dear To the Funeral Director n by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

<u>О</u>. Records, Vital 3 9 Division

> State Registrar

31. Date filed (Month, Day, Year) 1 2007

29b. Signature and (itle of certifier

(Check only one)

30. Name and

on who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Day 2007 March 11, **Physician** 9:00 AM M Charles Arthur Eiker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick United Cerebral Palsy Residence | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 957 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** 1 ∏M 2 □ F Mary Land 214-82-6294 49 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 2X No "natural", or items 23a or 28a-f sl dical Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6791 Sunnybrook Drive 21702 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes XXNo If Yes, Give Year or Dates: XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) None Never worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter C. Eiker Jean Frances Angleberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6791 Sunnybrook Drive, Frederick, MD 21702 Mrs. Jean F. Eiker, mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery March 14, 2007 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death 3 Months Immediate Cause (Final disease or condition resulting in death) Physician Adult Failure to Thrive /Medical Due to (or as a consequence of): Examiner from Birth Cerebral Palsy Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transitdeath certificate be executed and Due to (or as a consequence of) physician ar Box 68760, Physician/Medical ast IF FFMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Mental Retardation, uncontrolled seizures 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page After this certificate 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) UCP Home ٩ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 🙀 Natural 2 🔲 Accident Injury To the Hospital or Attendle within 24 hours af er death.
To the Funeral Director. At completely filled in by the fu 1 ☐ Yes 2 ☐ No · death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

luam

MAR 1 5 2007

William H. Convey,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Registrar's Signature

29c. License number

D 20395

195 Thomas Johnson Drive, Frederick, MD 21702

29d. Date signed (Month, Day, Year) March 12, 2007

within 24 hours a To the Funeral I

State Registrar DHMH 17 Rev 1/2001

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

LiL

FEB 2 8 2007

and manner stated.

South

Green

32. Registrar's Signature

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Baltimore MD

29d. Date signed (Month, Day, Year)

21201

Deportment of medicine

			1 - For State Registrar	State of	Marylan		artment o			d Mental Hy	giene Reg. No. 007	08180
	Physici /Medic		1. Decedent's Name (First, Middle, Last CLARA F	REEI	44/V	/				2. Date of Dea Month FEBRUS	Day _ Year	3. Time of Death 7 5:15 AM
	Examin		4a. Facility Name (If not institution, give		•		4b. City, Tow			eath	4c. County of Dea	th
			Hebrew Home of G					vill		U-a I - a	Montgo	
	Funeral		5. Social Security Number 6. Se	x ⊒M 2 X □F	7. Age (In yrs.	91 Yrs.	If Under 1 Y Months Da		Under 24 ours N	Min. (Month, Da	v, Year) Co	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent			91				Nov. 10	7, 1915 Ru	ssia
	/iand		10a. State 10b. County	**********	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Man F-f sh	ţ	Maryland Montgome	rv	Roo	ckvill	Δ					1 Yes 2 No
	r 282	irec	10e. Street and Number		110		10f. Zip Co	de			10g. Citizen of What Co	ountry?
	th wit	Funeral Directo	6121 Montrose Road	1			208	52			U. S. A.	
	dea	ner	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13.	Was Decedent	of Hispan	nic Origin'	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whit	
စ္တ	or It	F	1 Never Married 2 Married	Armed For 1 ☐ Yes If Yes, Give	2 X No		1 ☐ Yes 2 🛣		pecify:	, , , , , , , , , , , , , , , , , , , ,		nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Itams 23a or 28a-f show ither than "natural", or Itams 23a or 28a-f show ant, Ita Maukaal Examinar must be notified at	d by	3 ☑ Widowed 4 □ Divorced	Year or Da	tes:							
7	n 72	Completed	15. Decedent's Edi (Specify only highest grad	ication le completed)		(Give	dent's Usual Oi kind of work di DO NOT use re	one during		working	16b. Kind of Business	Industry
2	withii ene. than	щ	Elementary/Secondary (0-12)	College (1	4or 5+)		ales	3111 00)			Shoes	
0	Hyg Hyg other ent, I	ပိ	17. Father's Name (First, Middle, Last)					18.	Mother's	Name (First, Middle,	Maiden Sumame)	
<u>a</u>	id ba ental ked c	To Be	Ben Shulman					I	Esthe	er Joseph		
Maryland	should and Men a marke umatic		19a. Informant's Name/Relationship (T	rpe, Print)		19b. Mailir	ng Address (St	reet and N	Number o	r Rural Route Numbe	r, City or Town, State,	Zip Code)
	and 2 ealth a n 27 is		Barbara A. Rubin ·	- Daugh	ter	2429	McCorm	ick I	Road,	Rockvill	e, Md. 2085	50
ore	of He fitam		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Domovel from C		lace of Dispo	sition (Name o	of place)		Date	20c. Location - City or	Town, State
Ĕ.	Pages nent of B ant: If its ury or of		'4 □ Donation 5 □ Other (Specify,			ple Si	nai Me	m Pk.	. 2/2	28/2007	Plum Townsh	nip, PA.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene I by the Marylan I filem 27 is marked other than "natural", or I tams 23a or 28a-f show my portant: If item 27 is marked other than "natural", or other traumatic avent, I'te Mardical Examinar must be notified at once.		21. Signature of Funeral Service Licens	Potot	teme	2 DE	Name and A anzansk 170 Roc	y-Go kvil	faber 1e Pi	rg Memoria ike, Rockv	l Chapels, ille, Mary	Inc. land 20852
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that ca	used the eath							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ARI	TERII	71 ;	HYPE	FRIC	EN	510N		Onset and Death
	/Medical		resulting in death)	Due to (c	or as a conseq	V						
	Examiner		Sequentially list conditions.	5E1	VILE	: D	5ME1	V71	1 14			
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consequ	uence of):						
	and Ftran	хап	that initiated events resulting in death) Last	c. Due to (or as a consequ	neuce of).						
8760,	cate be executed physician and the burial-transit					20,100 0.7.						
687	The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached tor use as the burial-transit	Physician/Medical		d								
Вох	eath certific attending pl	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo			_				23d. Date of de	livery
ă	death a atte	iciai	in the past 12 months?	4☐Pregna	rth 2 ∏ Fetal ant at time of d		Ectopic pregn. Other (specif)				Month	Day Year
o.	t the c by the ached	hys	9 Unknown	9□ Unkno	wn							
ď.	res that the de signed by the a i be detached t	by P	Part II. Other significant conditions co	ntributing to de	ath but not resi	ulting in the u	nderlying cause	e given in	Part J.	23e. Did to	bacco use contribute to	the cause of death?
ğ	w require been sig should b	pa								1 🗆 Y	′es 2.22No 3Pr	obably 4 Unknown
သွ	e law re has bei je 2 sho	piet								24a. Was autop		utopsy findings available completion of cause of
Ĕ	The ate his	Completed								perfor	med? death? 2. 2 No 1 ☐ Yes	1/
ita	Attending Physician: Th r death. sctor: Atter this certificate by the funeral director, pag	Be (25. Was case referred to medical examiner?					26.	Place of	Death (Check only o		
<u> </u>	Physic this co	ပ္	1 ☐ Yes 2 D No			ER/Outpatier			Nursin	ng Home 5 ☐ Resid	ence 6 Other (Spe	cify)
Ē	ding P h. Atter (funera	on:	27. Many or of Death 1 ☑ Natural 5 ☐ Pending	28a. Date o (Month	f Injury o, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe h	ow injury occurred	
<u>s</u>	tend death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	OG Place	of laives . At he			1 TYes	2 🔲 No	204 Leasting (6	Name & and & Lorenberg and Di	and Courts Alicenters
	I or Attendater deatl Diractor: I in by the	Certification:	4 Homicide determined	buildin	of Injury - At ho g, etc. <i>(Specif</i>)	me, tarm, str /)	еет, тастогу, оп	rice		City or Tow	itreet and Number or Ri n, State)	urai Houte Number,
	ospital hours unaral ly filled	edical Co	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the	best of my kno	wledge, death	occurred at th	ne time, da	ate and pl	lace, and due to the occurred at the time	cause(s) and manner as date and place, and due	s stated.
	To tha He within 24 To the Fe complete	Medi	one)	and mann	er stated.							` '
	S T M	~	29b. Signature and title of certifier	J.	Do /11.	1 H	D 290. LIC	cense nun	354		29d. Date signed (Mont	*
•	1		Vincourse	all	ann	1 Vus		+ /	16			25,200 Z
			30. Name and address of person who come the second	NY, E	6121 H	ONTO	eost,	RD,	Rec	KVILLE	F, HP20	852
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 200	7	gistrar's Signa	ture	W.					

Examiner sician and burial-transit requires that the death certificate be executed P.O. Box 68760 physician the as asn for ed by the a detached f signed to Vital Records, page 2 Physician: director, Division or this funeral Atter Hospital or Attending within 24 hours after death To the Funeral Director: . completely filled in by the f

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

GH-4

State Registrar

Medical

29b. Signature and title of certifier

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

03/02/2007

Hogerstaun MD 21740

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician ELEANOR** FRALEY FEBRUARY 25 11:45P M W. 2007 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 6000 Granby Road-Sycamore Acres Derwood 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 7 19 6. Sex **Funeral** 1 M 2 F Months Days Hours Min Yrs. Director 191-14-9956 86 1920 Pennsylvania Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural; or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral, or items 23a or 28a-f show Examinar must be notified at Md. Derwood 1 Yes 2 No Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17800 Bowie Mill Road 20855 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: Specify: δ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event sine. Be Whitenight Margaret Manley Hughes Mathias ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17800 Bowie Mill Road, Derwood, Md. Kenneth H. Fraley / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 3/1/07 Laytonsville Cem. Laytonsville, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home mure P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician DEMENTIA 4 Years /Medical Due to (or as a consequence of): Examiner CEREBRAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. the 9 Unknown 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Diabetes Mellitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypothyroidism autopsy performed? certificate 2 □ No 2 No 1 Yes 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this Living After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 Homicide 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier FEBRUARY 26, 2007 D 23124 MWWW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2901 OLNEY-SANDY SPRING RD., OLNEY, MD. 20832 DENNIS M. HANNON, M.D. 31. Date filed (Month, Day, Year) FEB 2 8 Registrar's Signature State Registrar

1 - For Stete Registrar	State of Marylan	d / Department of H Certificate of I		Hygiene 17	08184
1. Decedent's Name (First, Middle, La	ast)		2. Date o		3. Time of Death
Physician /Medical Robert Eddie G		4b. City. Town, or	Location of Death		2:50 P M
115 Limestone Ro	ad	Hancock		Washingto	n
	Sex 7. Age (In yrs.	last birthday) If Under 1 Year Months Days	Hours Min. Apri	n, Day, Year) Coul	place (State or Foreign ntry)
0	10c. Cit	y, Town or Location			10d. Inside City Limits
MD Washing	ton Ha	ncock			Y☐Yes 2☐No
MD Washing		10f. Zip Code		10g. Citizen of What Cou	ntry?
in the stone R		21750	0 1-1-0 (0 1)	USA	
Too. State 10a. State 10b. County MD Washing 10a. Street and Number 10b. Street and Number 11b. Limestone R 11. Marital Status 11 Never Married 2 X Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Las 17. Father's Name (First, Middle, Las	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 25 No If Yes, Give^ Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Specify Yes o n, Mexican, Puerto Rican, etc. Specify:	Specify:	
Adamed 21215-0036 To strong the part of t		16a. Decedent's Usual Occup	ation	16b. Kind of Business/In	
Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired) working		
N September 15 On 17. Father's Name (First, Middle, Las	()	Laborer	18. Mother's Name (First, Mic	Agriculture	
E g g g a			Annie Celly N		
Lester Owen Gan		19b. Mailing Address (Street a		umber, City or Town, State, Zip	code)
		115 Limestone	Road Hancock,	MD 2175 0	
20a. Method of Disposition 1 \(\) \\(\) \(\)		lace of Disposition (Name of emetery, crematory or other plac	Date	20c. Location - City or To	own, State
Maurial 2 □ Cremation 3 [""" A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5 □ Other (Special Service Lice "" A □ Donation 5 □ Other (Special Service Lice """ A □ Donation 5		ne Bridge Cemet	ery 03/12/07	Hancock, MD	
21. Signature of Funeral Service Lice			141	west Main Str	
23a. Part1. Enter the disease, or con	plications that caused the deatl	// Grove Fune b. Do not enter the mode of dyin			Approximate
shock, or heart failure. List only Immediate Cause (Final dispase or condition		RSTRUCTURE	CI MCALARY	Dicence	Interval Between Onset and Death
/Medical resulting in death)	a. Due to (or as a consequence	BSTRUCTIVE F	J. C. Mich	21201	
Examiner Sequentially list conditions,	b	M. ON HOW			
any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a soneug	sense ot):			
cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last resulting in death) Last	C. Due to (or as a consequence	uence of):			
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and the death oearth oe	23c. If yes, outcome of pregna	nev			
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at the de state of the state o	9□ Unknown				
S S S S	contributing to death but not resi	ulting in the underlying cause give		Did tobacco use contribute lo to	he cause of death?
The law required to the la	CARDIOMYO	PA7114		Was an 24b. Were auto	ppsy findings available
Complete The Base of The Base	MELLITUC			performed2 death?	mpletion of cause of 2 No
25. Was case referred to medical examiner?		1	26. Place of Death (Check of		
A id a la la la la la la la la la la la la l		ER/Outpatient 3 DOA Othe	4 Nursing Home 3,2 F	Residence 6 Other (Special	ý)
LO 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury Work	rat 28d. Descr t? Yes 2 □ No	ribe how injury occurred	
27. Wanner of Death To a state death To a stat	De Ope Blees of Injury At he	ome, farm, street, factory, office	28f. Location	on (Street and Number or Rura r Town, State)	al Route Number,
olitat or urs after urs after in illed in the control of the contr					
Mining 24 hours after deal within 24 hours after deal or the Homicide and	miner: On the best of my kno miner: On the basis of examinal and manner stated.	wledge, death occurred at the tim tion and/or investigation, in my or	ie, date and place, and due to pinion, death occurred at the til	the cause(s) and manner as s me, date and place, and due to	tated. the cause(s)
19 Signature and title of certifier	DENAM R STA	INCY MD 29c. License	number	29d. Date signed (Month,	Day, Year)
1	Zhard IND	775	2112 [WO	3/8/50	
30. Name and address of person who	completed cause of death (Item	123a) (Type, Print) WM (QCL, MD	21750		
State Registrar 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture foods			

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

Certification: To 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide f 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00064055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERICMEDONAIDMD 7503 SURRATTS RD. CLINTON, MD 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

MAR 0 2 2007

e Funeral

To the Hosp within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:45 a M February 21, Maynard Warrington Gambrell 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 16821 Harbour Town Drive Montgomery Silver Spring Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year **Funeral** Days Hours 1 **⊠** M 2 □ F Yrs Director 578-70-5664 56 March 10, 1950 District of Columbia Usual Residence of Decedent 10d Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 K No Director **Maryland** Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with r than "natural", or Items 23a or the M dical Examiner must be 16821 Harbour Town Drive 20905 U.S.A. death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 2 No Specify ģ 3 Widowed 4 Divorced African-American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Senior IT Auditor Information Technology I and 2 should be filed wi Health and Mental Hygien III 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Warrington Gambrell Naomi Elizabeth McLeod ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a Reva J. Gambrell - Spouse 16821 Harbour Town Drive, Silver Spring, Maryland 20905 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State injury or Department Important: If any injury o Gate of Heaven Cemetery 3/1/2007 Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Lung Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown been signed by 1 should be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t page 2 s autopsy 1∐ Yes 2 No certificate Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 X Natural 1 Tes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō

Ö ۵ Division or Vital Records, after death. filled in by within 24 hours aft

To the Funeral D

completely filled in Hospital

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> State Registra

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 01 200



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date şigned (Month, Day, Year)

		•	1 - State Registrar	State of Maryl		partment of Heartificate of De			ene . No. 0 0 7	08187
	Physici		Decedent's Name (First, Middle, Last GWENDOLYN VIRG					2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 220-40-2392 10	× 7. AgeVin	yrs. last birthda 92 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth	<u> </u>	
	m w		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or	Location				10d. Inside City Limits
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	th with the 23e or 28s	al Director	10e. Street and Number 8507 MAPLEVILLE	ROAD		10f, Zip Code	21713		Citizen of What Cou	
900	d within 72 hours after deeth with the Maryland jene. rr then "neturel", or Items 23e or 28e-f show It e Medical Examiner must be maillied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	in U.S. 13	8. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☐ No	anic Origin? (Spec Mexican, Puerto F Specify:	eity Yes or No- lican, etc.)	14. Race - Amer Black, White Specify:	
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Maryland 21215-0036	should be filed ind Mental Hygi s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) GEORGE THOMAS S	TAUBS		18	8. Mother's Name MITTIE F	(First, Middle, Ma RANDOLPH	iden Sumame) GROVE	
	nd 2 stiffs ar 27 is		19a. Informant's Name/Relationship (7)	H, DAUGHTER	2060	iling Address (Street and 05 MILLPOIN	T ROAD, E	BOONSBOR), MARYLAN	D 21713
altimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 Surial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from State	MIN.	position (Name of ematory or other place) LEW CEMETER	Y 3/1/2	2007		, MARYLAND
Balt	permit. Pag Department Important; f eny injury o		21. Signature of Funeral Service Licens		E	22. Name and Address (BAST FUNERAL			NATIONAL P , MARYLAND	
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		al Status ever Married /idowed 4		- 1	Armed 1 ☐ Ye If Yes.	Forces? Solve Give Tates:		J.S.		Vas Deceder f Yes, specify I □ Yes 20		n, Mexican, I	Puerto F	lican, etc.)	NO-		Black, V Specify:	Vhite,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dealf **Physician** Year 07,2007 Philip Wayne Hixon 5:40 A. March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington

9. Birthplace (State or Foreign Country) NMS Health Care of Hagerstown Hagerstown . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Days 89 Director 217-12-2297 November 13,1917 PA Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director PA Fulton Warfordsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I Hygiene. other than "natural", or Items 23a of the Medical Examiner must b 1731_Lehman Road 17267 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatic event, the Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Hixon, Sr. Francina Weese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1845 Lehman Road Warfordsburg, PA 17267
ace of Disposition (Name of Date 20c. Location - City or Town, State R.Dale Hixon/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Buck Valley Christian 03/10/07 Warfordsburg. PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street MO14/4 Grove Funeral Home, P.A. Hancock, MD 21750-0368 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Discase **Physician** Corumany /Medical Due to (or as a consequence of): Diabatas Examiner Sequentially list conditions, trans, learning to interest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-transit chronic and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 ☐ Unknown s been signed by the should be detached Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has autopsy performed? this certificate 1∐ Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation within 24 hours arter coccur.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

W

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FARID

MUNSHED

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

DO60396

29d. Date signed (Month, Day, Year)

03/07/07

MD

			1 - For State Registrar	State of Marylan		rtment tificate					iene	0.7	0810	10
			Decedent's Name (First, Middle, Last)							2. Date of Death	1	<u> </u>	3. Time of De	ath
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	Examir		4a. Facility Name (If not institution, give st	reet and number)		4b. City, T	own, or	Location of			T	nty of Death		
			Joseph Richey Hos					imor						
	Funeral Director		5. Social Security Number 220-16-1774 Usual Residence of Decedent	7. Age (In yrs. 88	Yrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Dec. 14	, 191	9. Birthp Cour Mar	lace (State or F otry) yland	oreign
	within 72 hours after death with the Maryland ene. then *neture!', or items 23e or 28e-1 ehow he Medical Exertiter must be notified at		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						1	0d. Inside City L	imits
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	or 28	Olre	10e. Street and Number			10f. Zip 0	Code			10	g. Citizen o	of What Cour	ntry?	
	ath w	ral	2517 Barrison Poi	nt Rd.			21	221			U.S	.A.		
	er de	nue		Was Decedent Ever in U. Armed Forces?	.S. 13. V	Vas Decede Yes, specif	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe 1, Puerto F	cify Yes or No- Rican, etc.)		ace - Americ lack, White,		
36	I', or	by Funeral Directo	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:	1	☐ Yes 2	No No	Specify:			Spec	<i>ify:</i> Whi	tρ	
ŏ	2 hou	ted	15. Decedent's Educa	ation	16a. Deced	ent's Usuaf	Occupa	tion		1	6b. Kind of	Business/Inc		
21215-0036	Bn n	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work OO NOT use	done de retired)	u <i>ring</i> most	t of workin	g			,	
2	ygien ver th	Completed	11			mac	hini	st			ma	chiner	У	
pu	be fill d oth	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle, M	laiden Sumi	ame)		
2	d Mer narke	ပ	H. Paul Hull		1					aret En				
Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-1 show any injury or other traumatic svent, the Mudical Examilist must be notified at once.		19a. Informant's Name/Relationship (Type Yetive Habicht/ dau	·						Route Number,	_			
อ์	s 1 end 2 of Health a itsm 27 is other trace		20a. Method of Disposition	20b. P	2517 Place of Dispos	sition (Name	e of	- 1				, MD 2 n - City or To		
Baltimore,	Pages ent of nt: if i		1 ☐ ABurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movai from State	emetery, crem	-	•	1	2/26/					
E E	mit. F portar / inju		21. Signature of Funeral Service License		e Cree	Name and	Address	y a sof Facility	2/20/ 9 Har	2007 tzler F	nr. L	inwood 1 Homo	, MD	-
Ö	Depa impo sny i		(atharine	Xa Dler		10 Ch				w Winds				
П			23a. Part1. Enter the disease, or compfice shock, or heart failure. List only one	ations that caused the death	h. Do not ente	er the mode	of dying	, such as					Approximate Interval Between	en
	Physician		tmmediate Cause (Final disease or condition	Brain.	1.00	terest	0.	ـم بـ					Onset and Dea	th
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	1			>	1 51-				
П		-	Sequentiafly list conditions, b.	Orm to for as a consequent	ens	ma	-0	-6	C8 5	tate				
	nsit	Examiner	Cause (Disease or injury	200 10 (01 23 2 0513041	uerice or).		1)						
o,	exection and itelation	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):									_
1760,	ate be executed hysicien and the burial-transit	cal	d.											
99	leath certifica attending ph		IF FEMALE:					-						
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 Live birth 2 Tetal	death 3 🗌	Ectopic preg						ate of defive	ry Day Year	
o. _	at the de by the a stached f	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5□	Other (spec	cify)					NOTION	Day 18ai	
٠.	res that ti igned by be detac		Part II. Other significant conditions contr	ibuting to death but not resu	ulting in the un	deriving cau	ise diver	n in Part I.		23e. Did toba	acco use co	ntribute to th	e cause of deatl	h?
Vital Records,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	d by								1 🗆 Yes	2 🗆 No	3 Proba	ably 4 5Q nkr	nown
Ö	s been signature	olete								24a. Was an	24b	. Were autor	osy findings avai	ıfable
Ä.	Physicien: The fav this certificate has al director, page 2	Completed								autopsy		prior to con death?	nptetion of cause	e of
<u> </u>	striffice ctor. p	BeC	25. Was case referred to medical examiner?					26. Place	of Death	1 ☐ Yes 2] (Check only one		1 🗆 1 05	270 No	t
	Attending Physician: r death. sctor: After this certific by the funeral director.	٥	1 ☐ Yes 2 No Ho		ER/Outpatient	3□ DOA	Other	: 4 ☐ Nur	rsing Hom	e 5 ☐ Residen	ce 6 0	ther (Specify	Mont of	V.
ב	lfer ner	U	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Work?			3d. Describe how	v injury occu	urred	110	
Division of	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm etro	M I		es 2□N	_	8f. Location (Stre	act and Alum	abor or Over	Do to Marke	
É	after Dira	Certification:	4 ☐ Homicide determined	building, etc. (Specify	<i>'</i>)	ot, raciory, t	OTTICE			City or Town,	State)	iber or Adrai	noute rumper,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physic	ian: To the best of my know	wledge, death	occurred at	the time	, date and	d place, ar	nd due to the cau	use(s) and n	nanner as sta	ated.	
	To the He within 24 To the Fu completel	Medical	one) 2 Medical Examine	r: On the basis of examinat and manner stated.	ion and/or invi	estigation, ir	n my opi	nion, deat	n occurre	at the time, dat	e and place	, and due to	the cause(s)	
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	01/	1	29c. l	License			and the same of th	/	ed (Month, L	* '	
	154		" We used	Loterole	× L	0	10	\$58	821	7 0	2/2	6/0.	7	
V	6		30. Name and address of person who com	_	23a) (Type, P	rint)	10	~	2			M.	7	
	Stat	e	MARCE L. JORE 31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	LIOR	/ -	-1	135	LITENOR	ce 1	10 3	4207	
	Registra		MAR 0 2 21	107 Merca	K 1	breit	,							

Physician /Medical Examiner

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CAN ELIZABETH HARBOLD

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

an	Jean Elizabeth Harbold			1		Day 27, 2	Year 2007	2020 M
cal ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of				y of Death	2020
	Carroll Hospital Center	We	stmins	ter		Car	roll	
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Yea Months Days		24 Hrs. 8. E	Date of Birth Month, Day, Ye Ly 9, 1	ar)	9. Birthp Coun	lace (State or Foreign try) Jersey
	144-22-3249			Ju	Ly 9, 1	927	New	Jersey
	10a. State 10b. County 10c. City, Town or Loc	cation					1	0d. Inside City Limits
ţō	Maryland Carroll Westr	minster						1 ☐ Yes ② ☐XNo
irec	10e. Street and Number	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g.	Citizen of	What Coun	try?
al	552 Crossbridge Dr.	2115	8			USA		
nei	11. Marital Status 12. Was Decedent Ever in U.S. 13. V Armed Forces?	Was Decedent of If Yes, specify Cu	Hispanic Original	gin? (Specify , Puerto Rica	Yes or No-		ce - America	
Ϋ́F	1 □ Never Married 2 □ Married 1 □ Yes 2 No If Yes, Give 3 Widowed 4 □ Divorced Year or Dates:	1 □ Yes XX N	Specify:			Specif		Mite
Completed by Funeral Director	15 Decedent's Education 16a Deced	dent's Usual Occ	upation		16h	Kind of B	Business/Ind	
plet	(Specify only highest grade completed) (Give	kind of work don DO NOT use retir	e during most ed)	of working			ruon lobo, me	addity
E O	Elementary/Secondary (0-12) College (1-4or 5+) Homer	maker				own	Home	
Be (17. Father's Name (First, Middle, Last)		18. Mother	r's Name (Fire	st, Middle, Maid	len Surnai	me)	
2	Carl W. Reamer		I	Mary E	. Fidle	r		
		ng Address <i>(Stree</i> Sykesvi				•		<u>.</u>
	20a. Method of Disposition 20b. Place of Dispos		TTE KO	Date	tminste		- City or To	157
	1 ☑ Burial 2 □ Cremation 3 □ Removal from State cemetery, crem	natory or other p	· i				,	,
	4 □ Donation 5 □ Other (Specify) Deer Parl 21. Signature of Funeral Service Licensee 22			/3/200		TIOW TITMO	ou, M	aryland Chapel, PA
	John K Rall	12 Washi	naton 1	Rd. We:	runera. stminst	i nom er. M	ne and 1D 21	157
	23a. Pa Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.					-	Ī	Approximate Interval Between
		retizt-	Pailu	7.2				Onset and Death
	resulting in death) Due to (or as a consequence of):		1.1.00					MICHIE
L	Sequentially list conditions, b.							
nine	Sequentially list conditions, if any, leading to initialize cause. Enter Underlying Cause (Disease or injury							
xar	that initiated events resulting in death) Last c Due to (or as a consequence of):							
Completed by Physician/Medical Examiner	d.							
l edi								
an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Tectonic pregnan	cv				ate of delive	*
sici		Other (specify)				Mo	onth	Day Year
Phy	Part II. Other significant copditions contributing to death but not resulting in the un	nderlying cause o	iven in Part I		23e Did tobacc	O USA COR	tribute to th	e cause of death?
d by	Atrice Phzellahow	iaon, ng sauso g	Ton and a		1 ☐ Yes	2 No	3 ☐ Prob	
lete	proderma agranenosum			— II	24a. Was an	246	More autor	
ф	Ulcerative Colitis				autopsy performeg	?	prior to con death?	osy findings available npletion of cause of
Be Co	25. Was case referred to medical		26 Place	of Death (Ch	1 Yes 2 S	No	1 🗌 Yes	2 No
To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	t 3 DOA O	ther:		5 Residence	6 □Oth	ner (Specify	7)
nc.	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Injury (Month, Day Year) Injury	28c. Inj			Describe how in			·
cati	2 Accident investigation		∃Yes 2⊟N	No				
rtifi	4 Homicide determined 28e. Place of injury - At home, farm, streething building, etc. (Specify)	eet, factory, office	9		ocation (Street City or Town, St		ber or Rurai	Route Number,
S C	29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death	occurred at the	time, date and	d place, and d	due to the cause	e(s) and m	anner as st	ated.
Medical Certification:	(Check only 2 Medical Examiner: On the basis of examination and/or invane) and manner stated.	vestigation, in my	opinion, deat	th occurred at	the time, date	and place,	and due to	the cause(s)
Me	29b. Signature and title of certifler	29c. Licer	ise number			1	ed (Month, L	
	1 France K. Goldens In my	(Z)	31660		0	3/01	1500)
	30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)	JENUO	(1)00	TMIAICT	ez	maris	And ons)
	111011112 K. QUEVO II 27171	ONCIL II	11. 126	000	2,111,10,2,1		a see the of t	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Physician

/Medical

Director

Completed by Funeral

Be

၉

Examiner

Physician/Medical

Certification: To Be Completed by

Medical

Please	Type or Print State of Man						_	ble.	
1 - State Registrar	State of Ivial		rtificate of		ivierita	Reg.	00	07	08192
1. Decedent's Name (First, Middle, La: RAYMOND FRA		AINES			Moi	e of Death oth RUARY	Day 23, 2	Year 007	3. Time of Death 1:10 P M
4a. Facility Name (If not institution, given CROFTON CONVALESO			4b. City, Town, o		eath		4c. County ANNE		DEL
5. Social Security Number 6. S 184-22-9261	FILL OF F	n yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days		in. (Mo	e of Birth nth, Day, Ye	ea <i>r)</i> 1930	Cour	place (State or Foreign ntry) ISYLVANIA
Usual Residence of Decedent 10a. State 10b. County MARYLAND ANNE AR		DC. City, Town or Lo						1	l0d. Inside City Limits
10e. Street and Number 87 STEWART DRIVE	#215		10f. Zip Code 2103	 7			. Citizen of	What Cour	ntry?
11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No		Was Decedent of I	Hispanic Origin? pan, Mexican, Pu	(Specify Ye lerto Rican, e		14. Rac	ce - Americ ck, White,	
3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	If Yes, Give Year or Dates: 10	16a. Dece	1 □ Yes 2 ☑ No dent's Usual Occu			16	Specif b. Kind of B	, ,,,	HITE dustry
(Specify only highest gra	College (1-4or 5+)	`life. I	kind of work done DO NOT use retire TRONIC	during most of ved) DRAFTSMA			GOVERI CONTRA		G
17. Father's Name (First, Middle, Last, STUART KERMIT	HAINES			18. Mother's N			iden Surnar	ne)	
19a. Informant's Name/Relationship (EUGENIA HAINES/W	• • • • • • • • • • • • • • • • • • • •	1	ng Address <i>(Stree</i> EWART DR			-		. ,	*
20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Place of Dispo cemetery, crer HUNTT CRI	natory or other pla		Date 5/2007		c. Location - ALDORF	-	own, State
21. Signature of Funeral Service Licer	nsee		2. Name and Addr OBERT E.					ROAD,	BOWIE, MD 20715
23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a. A Due to (or as a c	clusti	c He	ing, such as card			,		Approximate Interval Between Onset and Death
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	c Ki	dney	Dis	Sea	×			Jeans
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)					te of delive	ery Day Year
Part II. Other significant conditions of	contributing to death but r	not resulting in the u	nderlying cause gi	ven in Part I.	_ 23	e. Did tobac 1	2 No		he cause of death? pably 4 □Unknown
					- _	a. Was an autopsy performed	g2		opsy findings available mpletion of cause of
25. Was case referred to medical examiner?	Hospital:		- 01	26. Place of E					
1 Yes 25 No 27. Manner of Death 15 Natural 5 Pending	28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of lnjury	28c. Inju	4 Nursin	g Home 5[28d. De		e 6 □Oth injury occur		(y)
2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		- At home, farm, str Specify)			28f. Loc City	ation (Stree or Town, S	et and Numb State)	per or Rura	al Route Number,
29a. Certifier (Check only one) 1 Certifying Pr 2 Medical Exar	nysician: To the best of r niner: On the basis of ex and manner stated	amination and/or in	h occurred at the t vestigation, in my	ime, date and ploopinion, death o	ace, and due ccurred at th	to the caus e time, date	se(s) and m e and place,	anner as s and due t	stated. o the cause(s)
29b. Signature and title of certifier	anna	MD	29c. Licen	se number	08	29d	Date signe	d (Month,	Day, Year)
30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print) VTFOXL			~ 1 15	M	020	710
31. Date filed (Month, Day, Year) FEB 2 8 200	32. Registrar's	Signature	N						~

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Shirley Marion Hawkins 2007 rebruary 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2**X**□ F 476-09-1076 Director 86 07/02/1920 Minnesota Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Prince Georges Glenn Dale Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20769 10012 Dubarry Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Maryland 21215-0036 Specify Specify: White If Yes, Give Year or Dates! 44–46 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. is marked other than College (1-4or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Vera Mae Talbert Erwin Edward Thomson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 10012 Dubarry Street Glenn Dale, MD 20769 Stacey L. Hawkins/ Daughter Baltimbre, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/28/2007 Waldorf, MD Huntt Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Euneral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovascular **Physician** Acute /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrillativ Chronic 1 Tes 2 No 3 Probably 4 Unknown Sezure 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 this certificate Deli ruum or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manyer of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death the 1 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours aft To the Funerai Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MB & 60611 LANHAM who completed cause of death (Item 23a)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) FEB 2 8

2007

2. Registrar's Signature

MO DOTEL

			For State		;	State of	Maryla			of Health and of Death	d Mental H	ygiene Reg. No	0007	08191
			Registrar 1. Decedent's Name	e (First, Middle	. Last)						2. Date of I		001	3. Time of Death
	Physicia	ın	The book of the tree of the tr			M.	Пол	ler			Month	Da		
3	/Medic		4a, Facility Name (/	Georg				161	4h City Toy	vn, or Location of D	Februar		. County of Dea	6:25 a. [™]
	Examin	er		ple Grov			201)			lver Spring				
-500:	Funeral		5. Social Security N		6. Sex		7. Age (In yrs	. last birthda) If Under 1 Y	ear If Under 24 I		Birth	Montgome 9. Bi	rthplace (State or Foreign
и	Director	ŀ	121-22-39		1 🔼 I	M 2□F	82	Yrs.	Months D	ays Hours N	Septemb	Day, Yea <i>r)</i> e r 14 .	4	New York
	- 148 JA		Usual Residence of								Popular			
	how at		10a. State	10b. County			10c. C	ity, Town or I	ocation					10d. Inside City Limits
	a-f s	턍	Maryland	Mont	gomer	у			S	ilver Sprin	g			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Nur	mber					10f. Zip Co	de		10g. Cit	izen of What C	ountry?
	23a ust b	<u>a</u>	515 Ap	ple Grov	e Roa	d				20904			U.S.A	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status		12	2. Was Deced Armed For		J.S. 13	Was Deceden	t of Hispanic Origin' Cuban, Mexican, P	(Specify Yes or I uerto Rican, etc.)	No-	 Race - Am Black, Wh 	
9	afte or it	드	1 Never Marr		ied	1 X Yes	2		1 ☐ Yes 2 🗷				Specify:	
Ö	ural";	d by	3 🛣 Widowed				tes:1944-							White
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21215-0036	withir	Completed	Elementary/Seco	ondary (0-12)		College (1-	4or 5+)			,		пс	C	D
2	Hygie Hygie Ther 1 nt, th		17. Father's Name	(First Middle	l ast)	5+) Sta	tisticia		Name (First, Midd		. Census	Bureau
anc	ntal led of	Be	_		2401)								, Garrianio)	
Ž	d Me d Me nark	ဍ	Joseph 19a. Informant's Na	Heller	nin /Tune	Drint)		10h Moi	ling Address (C	treet and Number o	illie Seif:		Town Ctato	Zin Codo)
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	1 and Health em 27 ther tr	ŀ	Sarah 20a. Method of Disp	Heller -	Daug	hter	20h.	Place of Disi	Freyman osition (Name o	Drive, Che	y Chase, I		nd 20815 ocation - City o	r Town State
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Ba	permit, Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.		21. Signature of Ft	,	Ceusee	4.			Hines-Rin	aldi Funera	al Home, In	ıc.		
		-	22a Part1 Enter t	carel	complic	tions that or	used the de	ath Do not o					Spring, N	laryland 20904
			shock, or hea		only one	cause on ea	ich line.	ani Bonoco	nior trio mode o	f dying, such as car	dido or roopiratory	urroot,		Approximate Interval Between Onset and Death
and the same of th	Physician / /Medical		disease or condition resulting in death)		_a.				chemia (S	Stroke)				
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	ted 1sit	ig	if any, leading to in cause. Enter Unde Cause (Disease or	erlying injury	<	24010(1		44401140 01/1						
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8760,	cate be executed oblysician and the burial-transit	a E												
687	phys the	dical			d.									
	death certific: e attending ph d for use as t	Physician/Me	IF FEMALE:		230	c. If yes, outo	ome pf preg	nancy					23d. Date of d	alivery
Box	atter for u	ciar	23b. Was deceden	months?		1☐Live bi	rth 2 ☐ Fe ant at time of	tal death 3	☐Ectopic pregr				Month	Day Year
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	requires that the de een signed by the a rould be detached f		Part II. Other signi	ficant condition	ons conti	ributing to de	ath but not re	sulting in the	underlying caus	e given in Part I.	23e. Di	d tobacco	use contribute	to the cause of death?
or Vital Records,	sign d be	d b	A1zhe:	imer's D	iseas	e					1[Yes 2	⊠ No 3 □ F	Probably 4 □Unknown
Ö	w requir been si should I	Completed									24a. W		OAh Word	utanay findinga ayailahla
Rec	The law ate has b	ᇤ									— au	topsy rformed?	prior to	autopsy findings available completion of cause of
<u>a</u>	r: The										1□ Ye	2 K No	1 ☐Y€	s 2 No
ΖÏ	ding Physician: The lav n. After this certificate has funeral director, page 2	Be	25. Was case reference examiner?		-	spital:				Other:	Death (Check onl			
0	Physral di	-T	1 ☐ Yes 2 ₹			1 ∐ Ir 28a. Date o		ER/Outpati 28b. Time	ent 3 DOA	4 LI Nursii	ng Home 5 K Re 28d. Describ			ecify)
n	dlng I. After funer	io	1 🔼 Natural	5 ☐ Pendin investig	g	(Monti	h, Day Year)	Injury	м 200.	Injury at Work? 1 ☐ Yes 2 ☐ No	ZOG. Descrip	e now mju	ny occurred	
isi	Attending r death. ector: Afte by the fune	icat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could i	not be	28e Place	of injury - At	home farm			28f Location	(Street a	nd Number or I	Rural Route Number,
Division	l or Attendatter death Director:	Certification:	4 Homicide	determ	inea	buildir	ng, etc. (Spec	cify)	treet, factory, o	#	City or	Fown, State	e)	ia.a. i routo rumbol;
	Hospital	ğ	29a, Certifier	1 X Certifyir	a Physi	cian: To the	hest of my k	nowledge, de	ath occurred at	the time, date and p	lace, and due to t	he cause/s	and manner	as stated
	To the Hospital or Attentwithin 24 hours after deatt To the Funeral Director:	Medical	(Check only one)	2 Medical	Examine	er: On the ba	sis of exami	nation and/or	investigation, in	my opinion, death	occurred at the tin	ne, date an	nd place, and di	ue to the cause(s)
	To the I within 2. To the I complet	Mec	29b. Signature and	title of certifie	r	and main			29c. L	icense number		29d. Da	ate signed (Moi	nth, Day, Year)
	F≯Fŏ			-		am				439 PZ6		1	2/201	

State

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DHMH 17 Rev 1/2001

Registrar

30. Name and address of person too completed cause of death (Item 23a) (Type, Print)

Damien J. Doyle, M.D., 1801 East Jefferson Str 1801 East Jefferson Street, Rockville, Maryland 20852

31. Date filed (Month, Day, Year) MAR 0 1 2007

			1 - For State Registrar	State of I	Marylar		artment of	Health and for Death		giene	07	08195
	Physic /Medi		1. Decedent's Name (First, Middle, La. Glen	,	Calvi	n	Hill		2. Date of De Month Februal	Day	Year 2007	3. Time of Death
	Exami		4a. Facility Name (If not institution, give 12900 Valley Ro		er)			n, or Location of Dea Cumberland			nty of Death	
)A	Funeral Director		270 21 0000	ex 7.	Age (In yrs. 77	last birthday) Yrs.	If Under 1 Ye Months Dar			y, Year)	Cour	place (State or Foreign ntry) nsylvania
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Alle	gany	10c. Cit	ty, Town or Lo	cation Cumberl	and			1	10d. Inside City Limits 1 Tyes 2 XNo
	h with the 13a or 28a st be noti	ai Director	10e. Street and Number 12900 Valley	Road, NI	E		10f. Zip Cod	2150		10g. Citizen	of What Cour	ntry?
980	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "netural", or Iteme 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ∑No		Was Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)		Race - Americ Black, White, cify:	
Maryland 21215-0036		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		or 5+)	(Give life. I	dent's Usual Ockind of work do. OO NOT use ret	ne during most of wo ired)	rking		Business/Ind	dustry
yland 2	and Mental Hygi Is marked other aumatic event, I	To Be C	17. Father's Name (First, Middle, Last) Brethard			Hill			me (First, Middle, E			Allabaugh
	D 5 1 2 0		19a. Informant's Name/Relationship (Helen A. Hill / W			12900	Valley	Road, NE	., Cumbe	rland,	MD 2	21502
Baltimore,	Pa ant ury		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	<i>'</i>)	te	nset Me		Park 02/2		Cumbe	rland,	MD
Bal	Departi Departi Importi any Inju		21. Signature of Feberal Service Licer	alla		41	04 Deca	tur Street	c, Cumber	·land,		Home, P.A. 1502
A. 4	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Mefa	sed the death in line. AS R R as a conseq	ic /	I sale		c or respiratory ar		7 (Approximate Interval Between Onset and Death
8760,	rate be executed shysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a conseq as a conseq							
O. Box 6	death certific e attending p id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of d	I death 3	Ectopic pregnal			1	Date of delive	ery Day Year
ords, P.	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions of	ontributing to death	but not res	ulting in the un	nderlying cause	given in Part I.		bacco use co ′es 2□No		ne cause of death?
Vital Records,		Completed							24a. Was a autop perfor 1 🗆 Yes	sy	prior to cor death?	psy findings available mpletion of cause of 2 No
₹	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		50.0		Date	ath Check only or			
Division of	Attending Phy ir death. ector: After this by the funeral d	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L		ER/Outpatien 28b. Time of Injury	28c. In	4 🗆 Nursing r	28d. Describe h			<u>()</u>
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	Injury - At ho	ome, farm, stre	eet, factory, office	ee .	28f. Location (S City or Tow		mber or Rura	d Route Number.
	he Hospital or in 24 hours afte the Funeral Dir pletely filled in I	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the be- liner: On the basis and manner	of examina	wledge, death tion and/or inv	occurred at the restigation, in m	time, date and place y opinion, death occu	and due to the curred at the time, c	ause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
)	To the within 2	M	29b. Signature and title of certifier	m 6	1/1	i whi		5135		ed. Date sign Februa		
	nes		30. Name and a sess of person who of Thomas E.	Chappell	, M.D	., 912		Drive, Cu	mberland	, MD	21502	
134	Sta	ite	31. Date filed (Month, Day, Year) FFB 2 3 20	32. H égis	strar's Signa	ture	mark p					

			For 1 State	State of Maryla				Mental Hy	giene	007	09196
			1 State Registrar 1. Decedent's Name (First, Middle, La	ct)	Cen	tificate of	Death	2. Date of De	Reg. No	001	00170
	Physic		11.1	. 11	bleto			Month 3	Day	Year 2007	3. Time of Death
Jan 1	/Medi Examir		4a. Facility Name (If not institution, give		OIC TO		or Location of Dea			County of Death	
				spital	5-41:0	ĿK.	ton			Cecil	
	Funeral Director		5. Social Security Number 6. S	Dex 0 7. Age (in yrs	. last birthday) _ Yrs.	Months Days	If Under 24 Hr Hours Mir	8. Date of Bi	rth ay, Year) 25-19.	9. Birthpla Count	ace (State or Foreign
			Usual Residence of Decedent	140- 0							
	//anyla	or	10a. State 10b. County	106. C	ity, Town or Loc	ation				10	d. Inside City Limits 1 Yes 2 No
	1 the P	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Count	
	23a o	aiD	170 Vista	· Dr		21	921		- (USA	
	er dee	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. W	as Decedent of H Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	D- 14	4. Race - America Black, White, e	
036	72 hours after deeth with the Maryland naturel', or items 23a or 28e-f show ilsel Examinar must be routiled at	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	11	☐ Yes 2KNo	Specify:		S	Specify: Wh	nite
21215-0036	72 hours naturel', dicel Exp	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Decede	ent's Usual Occup	pation during most of we	orkina	16b. Kind	d of Business/Indi	ustry
121	d within 72 h piene. r than "natu rre Medicel	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)		i	during most of we	······· y	Rout	Est 1.	70-6-6-6
	E F E	0	17. Father's Name (First, Middle, Last			ent	18. Mother's Na	ıme (First, Middle			Drugano
/lan		To B	Clarence	H. And	Jerso	γ	He	len	G	een	
Maryland	and and is m	W	19a. Informant's Name/Relationship (1 1 1 1	4	Address (Street	and Number or F	11/1.	er, City or	Town, State, Zip (
	Heelth Heelth tem 27 other tr		20a. Method of Disposition	oleton/husbane	Place of Disposi	VISTO	Dr. E	Date	20c. Loca	21921 ation - City or Tow	
E E	0°==		1 ☐ Burial 2 KCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, crema Awn (Not	atory or other place		-3-07	4	wood, I	an
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lio						ecley	Family F	uneral Him
	80 F # 9		relieval.	Millown	- (035 Ch	urchman	nika	Newa	WK DE	19702
			23a. Part1. Enter the disease, or copshock, or heart failure. List only tmmediate Cause (Finat	plications that caused the dea one cause on each line.	th. Do not enter	r the mode of dyir	ng, such as cardia	ic or respiratory a	rrest,		Approximate Interval Between Onset and Death
Ž.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec	atonu	fail	ure.				
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9	ertifica ding ph	/Med	IF FEMALE:	00- 4	==						2.25
Box	et the death certifics I by the attending phatached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 □E	Ectopic pregnancy Other (specify)	,		23	d. Date of delivery Month D	y Day Year
Ö.	t the c by the tachec	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown							
ري ص	igned be de	þ	Part It. Other significant conditions of	ontributing to death but not res	suiting in the und	derlying cause giv	en in Part I.	į		contribute to the	
oro	v requir been s should	eted						10	Yes 2		
Vital Records,	The law cate has I page 2 s	Completed						24a. Was autopento	an osy ormed?	24b. Were autops prior to com death?	sy findings available ptetion of cause of
ital		ø	25. Was case referred to medical			_	26 Place of De	1 ☐ Yes ath (Check only o	2 No	1 ☐ Yes 2	!□ No
of <	S S D	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient	3□ DOA Oth		dome 5 ☐ Resi	- 100	□Other (Specify)	
	ling P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of tnjury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe	how injury	occurred	
Division	Attending r death. ector: Afte by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not b		ome, farm, stree		Yes 2 □No	28f. Location /	Street and	Number or Rural	Route Number
Ö	s after et Dire ed in t	Certification:	4 Homicide	building, etc. (Special	fy)	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State)		,
	Hospi 4 hour Funer tely fills	edical	(Onech only Z Medical exam	ysician: To the best of my knoniner: On the basis of examina	owtedge, death of ation and/or inve	occurred at the tin	ne, date and plac pinion, death occ	e, and due to the	cause(s) ar	nd manner as stai	ted.
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens				signed (Month, Di	
	⊢ ≶ ⊢ ŏ		Marin 1	6/1/14					,	1/07	,. · //
			30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Pr	rint)	-	elkter	3/ 1	101	
(0		31. Date filed (Month, Day, Year)	ak Chion H	ospital	106	Bow St	elklor	THE	>	
	Sta Registr		31. Date filed (Month, Pay, Year)	32. Registrar's Signa	J. A.	bester					

			For State	State of	Marylan			nt of H te of L				giene Reg. No	000	7	0.8	197
	-		Registrar 1. Decedent's Name (First, Middle, Last	t)							2. Date of De	ath	kon V	7 1	3. Time o	of Death
	Physici		ROBERT BRUCE	HOSFO:	RD						Month FEBRUA	ARY :		Year 007	9:0	5 P M
	/Medic		4a. Facility Name (If not institution, give	street and num	iber)		4b. City	, Town, or	Location	of Death		40	. County o	f Death		
1.			Holy Cross Hosp:	ital			S	ilver	Spr	ing				tgom	ery	
	Funeral		Social Security Number 6. Security Number		7. Age (In yrs.		If Und	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthpl Count	ace (State	or Foreign
	Director	į	398-16-4241	⊠ M 2□F	82	Yrs.					Sept.	8 19	924		consi	n
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	Od. Inside (Dity Limits
	shov shov	<u></u>	Md. Montgon	10257		larksb									1 □ Yes	s 2 No
	the M	ect	10e. Street and Number	пету				p Code				10a. Ci	tizen of W	hat Coun	trv?	
:	aor	Funeral Director	24301 Stringtown	n Road			701.2	p 0000	208	71		0	Jnite			
	ns 23	eral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Dec	edent of Hi			ecify Yes or No Rican, etc.)		14. Race			
	riten iner	듄	1 □ Never Married 2 Married	Armed For 1 Yes	2 □ No			- 1			Rican, etc.)			, White, 6		
	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	e ites: W W	III	1 ☐ Yes	2⊠ No	Specify.	:		ĺ	Specify:	Wh:	rce	
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2	d oth	Be	17. Father's Name (First, Middle, Last)	_							(First, Middle			;)		
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<u>ק</u>	hand hand risin traum		19a. Informant's Name/Relationship (7)		2						al Route Numb Clark				20871	
֡֡֝֡֜֝֜֝֡֓֓֓֓֜֜֜֝֜֜֜֝֜֜֜֜֜֜֝֜֜֜֜֝֜֜֝֜֜֝֜֜֝֜֝֜֜֝֝֜֜֝֡֜֝֜֝֡֡֡ ֓֓֓֓֓֓֓֓֓֞֓֓֓֓֓֜֜֜֓֓֓֓֓֜֜֜֓֓֓֜֜֜֓֓֓֜֜֜֜֓֓֜֜֜֜֜֜	T and Healt em 2 ther		20a. Method of Disposition	, ,	20h. F	Place of Dispo	sition (N	ame of	1		ate		ocation - 0			
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🗖 Cremation 3 🗌		state I	cemetery, crei		-		2/27	7/07	A]	exan	dria	. Va.	
	ntme		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License													
ם	Depar Impor any Ir		> Muriel F	Y-12	arke						Funera Layton			M.Z	2088	2
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	cuted	Examiner	that initiated events	C												
9	ate be executed hysician and the burial-transit	ĕ	resulting in death) Last	Due to (or as a conseq	quence of):										
	cate be executed physician and the burial-transit	dical		d												
9 ; YO	Ine law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, out	come of prean	ancv							23d. Date	of delive	n/	
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,	the d	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno				, ,,								
_ :	that hed by deta		Part II. Other significant conditions co	ontributing to de	ath but not res	sulting in the u	nderlying	cause give	en in Part	I.	23e. Did	tobacco	use contri	bute to th	e cause of	death?
COLUS,	quires n sign	d by	DIABETES								10	Yes 2	2□ No	3 ☐ Prob	ably 4 💆	∐Unknown
2	s bee	lete									24a. Was		24b. W	ere auto	osy finding	s available
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> :	ysici is cel direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1頃』	npatient 2] ER/Outpatier	nt 3 🗆 🛭	Othe	er: 4□N	ursing Ho	me 5□Resi	idence	6 □Othe	r <i>(Sp</i> ec <i>if</i>)	1)	
5 1	ng Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of	of Injury h, Day Year)	28b. Time o Injury	f	28c. Injun Work	/ at </td <td></td> <td>28d. Describe</td> <td>how inju</td> <td>ary occurre</td> <td>ed</td> <td></td> <td></td>		28d. Describe	how inju	ary occurre	ed		
5	endir ath. or: A he fu	ätic	2 ☐ Accidentinvestigation				М		Yes 2□							
	or Att ter de iirect n by t	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place buildir	of injury - At h ng, <i>e</i> tc. <i>(Speci</i>	ome, farm, sti <i>fy)</i>	reet, facto	ry, office			28f. Location <i>(</i> City or To	Street a wn, Stai	nd Numbe te)	r or Rura	l Route Nu	mber,
ָ ב	To the hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	O	29a. Certifier 1 Certifying Phy	reician: To the	heet of my kno	owledge deat	th occurr	rd at the tin	ne date a	and place	and due to the	Called	s) and mar	nner as st	ated	
:	24 ho 24 ho Fun etely	ledical	(Check only 2 Medical Exam	niner: On the ba	asis of examina	ation and/or in	vestigati	on, in my o	pinion, de	ath occur	red at the time	, date ar	nd place, a	nd due to	the cause	(s)
:	vithin To the	Me	29b. Signature and title of certifier	,	7		2	9c. License	number			29d. D	ate sign <i>e</i> d	(Month,	Day, Year)	
	let l		> Call	18	and the same of th			00	6508	8		FE	BRUA	RY 26	5, 20	07
,	ue · ·		30. Name and address of person who	completed caus	e of death (Iter	m 23a) (Type,	Print)						2001			
			JOYDIP ROY, M.D.	. 150	OO FORE	ST GLE	N RC	AD, S	ILVE	R SPI	KING, M	ш.	2091	U		
	Sta		31. Date filed (Month, Day, Year) FEB 2 8 206		egistrar's Sign	ature	and I									

DHMH 17 Rev 1/2001

ORIGINAL

07-01612 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jeffrey P. Hathaway State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day February 27, 2007 Medical Examiner Jeffrev P. Hathaway 1715 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 993 C Heather Ridge Drive Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Funeral Months Days Hours Director Country Maryland 1X M 2 F 1964 524-92-9572 19, 43 Feb. Usual Residence of Decedent 1 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No 28a-f show or items 23a or 28a-f sho must be notified at once, Maryland Frederick Frederick after death with the Maryland 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 993 C. Heather Ridge Drive 21702 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Married 2 X No Yes White 4 X Divorced 1 Yes 2X No specify: 3 Widowed f Yes, Give Year Specify <u>۾</u> more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours a near of Health and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical If item 27 is marked other than +4 Addictions Councilor Rehabilitation 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Craig Hathaway Mary Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic Craig Hathaway / Father 9415 Glade Ave., Walkersville, MD 21793 20a Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, crematory or other place) Resthaven Mem. Garden 3/3/2007 Frederick, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 our their Jau Part I. Enter the disease, or complications of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line 8etween Onset and /Medical a Multiple Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown s been signed by the a should be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 V No 3 Probably 4 Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has page 2 s performed? death? ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject stabbed and cut self **FOUND** Natural 1 Yes 2 V No Pending Feb 27, 2007 1709 hrs Investigation

Division of Vital Director:

the

Accident

Homicide 29a. Certifier 1

3 V Suicide

Hospital or Attending Physician: within 24 hours a To the Funeral I

29b. Signature and title of certifie

Could not be

determined

29c. License number O.C.M.E

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d Date signed (Month, Day, Year) February 28, 2007

28f. Location (Street and Number or Rural Route Number, City

or Town, State) 993 C Heather Ridge Drive, Frederick, MD

Death

Year

Unknown

2 No

30 Name and address of person who completed cause of death (Item 23a)

Year) 2 2007

Patricia Aronica-Pollak MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

28e. Place of Injury - At home, farm, street, factory, office building, etc

31. Date filed (Month, Day, State Registra

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OCME 2006

Medical

one)

(Specify) residence

and manner stated

			State of Marylan					_	00100
	Av		1 - State RegistraMEND#31See#323/1/07,BMW,McCo	Cei	rtificate of De	eath	R	eg. No. UU /	UBIJJ
7	Physic	ian	Decedent's Name (First, Middle, Last)			1	2. Date of Dea Month	Day Year	3. Time of Death
	/Medi	cal	Marjorie Givens Jackson				02-27		12:30P M
1	Exami	ner	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital		4b. City, Town, or Loc Takoma Par			4c. County of Dea	
1	Funeral	200	5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)			B. Date of Birth	Montgomer	J
1. 2. 2.	Director	, 83	233 20 9878 1 M 2 F 88 Usual Residence of Decedent	Yrs.	Months Days F	lours Min.	(Month, Day 06-28-	Year) C	rthplace (State or Foreign ountry) MO
	show	70	300	y, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 X No
	r 28a-1	Funeral Director	MD Anne Arundel Laur 10e. Street and Number	cel	10f. Zip Code		1	0g. Citizen of What C	
	th wit	aiD	355 Chaptico South		20724			USA	
	r dea	Iner	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	nic Origin? (Spec	rfy Yes or No-	14. Race - Am Black, Whi	
900	72 hours after death with the Maryland natural', or items 23a or 28a-1 show distal Exament roust be notitled at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, 2 No If Yes, Give Year or Dates:		_ 37_	pecify:	,	Specify: Wh	
21215-0036	d within 72 ho piene. r than "natur r na Madical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	7	16b. Kind of Business	/Industry
21	od witi	Com	2	Teach	ers Aide			Educa	tion
Maryland	uld be filed fental Hygir rked other ilc event, il	To Be	17. Father's Name (First, Middle, Last) Albert Givens			Mother's Name (Sybil Bob		Maiden Sumame)	
ary	2 should and Men is marke sumatic	_	19a, Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and	Number or Rural i	Route Number	, City or Town, State,	Zip Code)
	DEN		Shelia A. Gwinn -daughter	355 Cl	napitico So	uth, Lau	rel, M	D 20724	
ore	ges 1 an t of Heali If itam 2 or other		20a. Method of Disposition 20b. Pl	lace of Dispo emetery, cren	sition (Name of natory or other place)	Dat		20c. Location - City or	Town, State
Ë	mit. Pages partment of cortant: If its injury or o		4 □Donation 5 □ Other (Specify) Blu		ge Memorial	1	2007	Beckley, W	V
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee		Name and Address of Uscons	Jose		ler's Sons	
*	\$. 28 %		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not ent	er the mode of dying, su	uch as cardiac or	espiratory arre	est,	Approximate Interval Between
1	Physician								Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequ	ience of):	> 2-				27
	LXdiffiller	<u>.</u>	Sequentially list conditions, b. Cormany A.	very	prisease				80 years
	nsit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	sence or w	esterolomo	'a			50 wears
	be execuician and burial-tran	xar	that initiated events resulting in death) Last c. Due to (or as a consequence of the cons	ience of):	0-1-0-10-0-				50 years
760,	ysiciar	cal	d. Hyperter	nim					50 years
9	ntifica ng ph as th	Medi	IF FEMALE:						
P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burtal-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M/No 9 □ Unknown 23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 [Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ds, P	w requires that the de been signed by the should be detached	d by Pr	Part II. Other significant conditions contributing to death but not resu Congesting Heart Failure	Iting in the un	nderlying cause given in	Part I.		pacco use contribute to	
Ö	v requ	ete	Danne Tilune						
Division of Vital Records,	: The lay cate has	Completed by	Revice factor a				24a, Whas ar autops perform 1 Yes 2	y prior to	utopsy findings available completion of cause of
<u> </u>	sician certifi rector	Be	25. Was case referred to medical examiner? Hospital:		0**	Place of Death (
ō	Phys r this ral di	2	1 Inpatient 2 E	ER/Outpatient 28b. Time of				nce 6 Other (Spe	city)
o	ding th. Afte fune	tion	27. Manper of Death 1. Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes		i. Describe no	w injury occurred	
Oivisi	I or Atter after dea Director I in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre			Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2	Medical Ce	29a. Certifier (Check only one) 29 Medical Exeminer: On the basis of examination	vledge, death ion and/or inv	occurred at the time, directigation, in my opinion	ate and place, and	d due to the ca	use(s) and manner as	stated.
	ithin 2 or the	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License nur			d. Date signed (Mant	
)	LQ EBE8		. G. Chatrathi MD		521	-	23	2/27/0	7
v.			30. Name and address of person who completed cause of death (Item Suife 302, \$100 Goodbuck	23a) (Type, F	Print) Sridhar	Chatrath MD	DOIO'S		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signati						
	Registr	ar	2-27-07 MAR 0	1 2007	A STATE OF THE PARTY OF THE PAR	15 Ass			

			For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F rtificate of			giene Rag. No.	007	08200			
			1. Decedent's Name (First, Midd	le, Last)				2. Date of Dea	ath Day	Year	3. Time of Death			
	Physici /Medio		JACQUELYNN MARI	E JONES				FEBRUAR			11:45 AM			
	Examir		4a. Facility Name (If not institution	n, give street and num	ber)	4b. City, Town, o	r Location of Dea	ith	4c. Cc	ounty of Death				
			RUXTON HEALTH		and the second second	DENTON If Under 1 Year	If Under 24 Hr			OLINE				
	Funeral Director		5. Social Security Number 205–32–9884	6. Sex 7 1 ☐ M 2 💢 F	. Age (In yrs. last birthday, 63 Yrs.	Months Days	Hours Mir			Coun	lace (State or Foreign stry) SYLVANIA			
	and w		Usual Residence of Decedent 10a, State 10b, County	<u> </u>	10c. City, Town or L	ocation				1	0d. Inside City Limits			
	Marylan f show	ō	MARYLAND CAROI	TNF	DENTON						1 ☐ Yes 2 X No			
	the rotin	rec	10e. Street and Number	JIND	DENTOR	10f. Zip Code			10g. Citizer	n of What Coun	itry?			
	h with	Funeral Director	8158 HARMONY R	OAD		21629			USA					
	deat	ner	11. Marital Status		lent Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No-	14.	Race - Americ Black, White,				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinar must be routiled at ODGe.	by Fu	1 ☐ Never Married 2 🙀 Mar 3 ☐ Widowed 4 ☐ Divorced	rried 1 ☐ Yes 2	X No	1 ☐ Yes 2 No	Specify:	ito Alcan, stc.,	St	pecify: WHIT				
Ö	2 hou	ted		nt's Education	16a. Dece	dent's Usual Occup	ation	a dein a	16b. Kind	of Business/Ind	dustry			
21	thin 7	Completed	Elementary/Secondary (0-12)	completed) College (1-4	4or 5+)	kind of work done DO NOT use retired	d) -	orking						
	ed wi	Son		4	SCHO	OL TEACHE				ATION				
Maryland	be fill d oth	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Na	ame (First, Middle,	Maiden Su	ımame)				
<u>₹</u>	Men Marka Marka	2	EARL HAMMOND				ANN CAS							
Mar	12 sh h and 7 is m treum	10	19a. Informant's Name/Relations			ing Address (Street					·			
	1 and Heatt em 2 ther	N	CHARLES JONES/ 20a, Method of Disposition	HUSBAND	20b. Place of Disp	HARMONY	ROAD, DE	Date		D 21629 tion - City or To				
Baltimore,	ages nt of 1 t: ff ite		1 🗆 Burial 2 🗶 Cremation		tate cemetery, cre	matory or other plac		CH 1,		-				
ij	artme artme ortent injury		' 4 □ Donation 5 □ Other (5			CE CREMAT		2007	STEVE	NSVILLE	,MARYLAND			
Ba	Depar Impor any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL 106 SHAMROCK ROAD, CHESTER, MARYLAND 2											
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that can t only one cause on	and the death. Do not en	ter the mode of dyin	ng, such as cardia	ac or respiratory ar	rest,	nii - Antoled Se	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	END	- STAGE	DEUNEN	MIA				Onset and Death YEARS			
	/Medical Examiner		resulting in death)	Due to (o	r as a consequence of):									
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	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	d Due to (o	ras a consequence of):									
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy				230	1. Date of delive	ry			
B.	death e atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 🔀 No	4□Pregna	nt at time of death 5[⊒Ectopic pregnancy □ Other (s <i>pecify)</i>	·			Month	Day Year			
0	t the by the	hys	9 Unknown	9□ Unknov	vn .			-						
ď,	res that the de signed by the a be detached f	by P	Part II. Other significant conditi	ons contributing to dea	th but not resulting in the u	ınderlying cause gıv	en în Part I.	23e. Did to	bacco use	contribute to th	e cause of death?			
ğ	w require been sig should b	ed						1 🗆 Y	es 2 1	No 3 ☐ Prob	ably 4 □Unknown			
Records,	has be	Completed						24a. Was			osy findings available			
Ä	The ate has page	mo;						perfo		death?	2. No			
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	ıl			26. Place of De	eath (Check only o						
of V	Physic this ce al dire	2	1 ☐ Yes 2 No	Hospital: 1 🗆 Inj	patient 2 ER/Outpatie	nt 3□ DOA Oth	er: 4% Nursing	Home 5 ☐ Resid	ence 6	Other (Specify	<i>'</i>)			
n			27. Manner of Death 1. ■ Natural 5 □ Pendir	28a. Date of (Month)	Injury 28b. Time of Injury	Wor		28d. Describe h	ow injury o	ccurred				
sio	ottendi death. ctor: A y the fu	cat		igation not be			Yes 2 □ No							
Division	after d Diract Jin by	Certification:	4 Homicide determ	nined 200. Place o	f Injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow		lumber or Rura.	l Route Number,			
	pital ours a erel [29a Carifica	na Physician T. d.	and of my lenguist	h conversed as the same	no dot 1	 		4	d			
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying 2 Medical	Examiner: On the bas and manne	est of my knowledge, deat is of examination and/or in or stated.	vestigation, in my o	pinion, death occ	eurred at the time, o	ause(s) an late and pla	u manner as st ace, and due to	the cause(s)			
	To th withir To th comp	Me	29b. Signature and title of certific		4.5	29c. Licens	e number	0.7	29d. Date s	igned (Month, L	Day, Year)			
	ill		Mah	ATTENDI	6 MD	De	023c	>74	3-	1-0	7			
	1 **		30 Name and address of person	who completed cause	of death (Item 23a) (Type,	Print)	A		-		10			
	5)			MBOLD NO	D321 Bu	DOMIN GD	ALE AL	1£ 1=062	ALS F	3026,1	11021632			
	Sta Registr		31. Date filed (Month, Day, Year)	1 2007 32. Re	of death (Item 23a) (Type, 321) Bud Signature	Spark								

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month **Physician** 7:00 aM John Wills Kuykendall February 23, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Rehab and Nursing Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F Yrs Director 526-42-2966 73 November 16,1933 Phoenix, Arizona Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: If ten 27 Is marked other than "natures" ----any injury or other tre-------------10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 K No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1411 Leister Drive 20904 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑Yes 2 □ No If Yes, Give Year or Dates: Korean War 1 Never Married 2 x Married 1 ☐ Yes 21 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Auditor GAO U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Dolph Kuykendall Maude Wills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Kuykendall - Daughter 1411 Leister Drive, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Quantico National Cemetery 2/28/2007 Triangle, Virginia 21. Signature of Funeral Sewio Vicensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Aa. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, go neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Poorly Differentiated Prostate Cancer 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 99 1 Yes 2 No 3 Probably 4 Unknown Completed Obstructive Uropathy Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an **Urinary Tract Infection** certificate has autopsy performed? page Bilateral Pleural Effusions 2 K No rector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Certification: To 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospitel or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier (Check only one) 29b. Signature and le of certifier 29c. License number 29d. Date signed (Month. Dev. Year) nny JIM D0052401 D February 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 Lockwood Drive, Suite 205, Silver Spring, Maryland Thomas M. Annulis, M.D. 31. Date filed (Ma Registrar's Signature State 2007 Registrar

r ate	State of Maryland / Department of Health and Certificate of Death		08202
gistrar	Octimodic of Death	Reg. No.	
dent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death

		For State Registrar		State	of Ma	aryland / Depa <i>Cer</i>	artment of F ctificate of a			Mental		iene 2 () eg. No.	07	08202
Physician /Medical		1. Decedent's Nam Davi		Loveri				2. Date Feb		, 2 007	Year	3. Time of Death 0540 M		
Examine		4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Center					4b. City, Town, or Location of Death Glen Burnie					4c. County of Death Anne Arunde1		
Funeral Director		5. Social Security N 001-28-7		6. Sex 1 X M 2 ☐ F	7. Ag	e (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date (Mont	h, Day,		Cou	place (State or Foreign intry) NH
D		Usual Residence of	Decedent											
lan ow		10a. State	10b. County	1		10c. City, Town or Lo	cation							10d. Inside City Limits
the Marylan 28a-f show notified at	ctor	MD	Anne .	Arundel		OD	ENTON							1 □Yes 2XNo
	Dire	10e. Street and Nu 2442 Blu		ng Court	Un i t	: 104	10f. Zip Code 21	113			10	og. Citizen of V USA		ntry?

12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
!f Yes, Give 61-63 1 ☐ Never Married 2 Married r Yes, Give 61–63 Year or Dates: 1 ☐ Yes 2 🌠 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gov't Contracts Project Specialist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loverin Alfreda Ralph Μ.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2442 Blue Spring Court Unit 104 Odenton, MD 21113 Janet Loverin Spouse

20b. Place of Disposition (Name of cemetery crematory or other place)
Metro Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD Feb. 27,07 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Hardesty Funeral Home P.A 851 ala 23a. Part1. Enter the disea of, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

disease or condition resulting in death)

Immediate Cause (Final disease or condition

Funeral

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Completed

Be

2

Examine

Physician/Medical

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Completed

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Certification: To

Medical

State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

A.	te exacerbation of Chronic obstructive julmorray)	Onset and Death
	Due to (or as a consequence of):	
b. =	Due to (or as a consequence of).	
C	Due to (or as a consequence of):	
_ d		

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

29b. Signature and title of certifier

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9☐Unknown

23e. Did tobacco use contribute to the cause of death? 1X Yes 2 No 3 Probably 4 Unknown

> 29d. Date signed (Month, Day, Year) 27/07

14. Race - American Indian. Black, White, etc.

24a. Was an autopsy perform 2 X No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Day

25. Was case referred to medical examiner?		26. Place of Death Check onlone										
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	ER/Outpati	ent 3 DO	Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)						
27. Mariner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time Injury	of 28	Bc. Injury at Work?	28d. Describe how in							

occurred investigation 1 ☐ Yes 2 ☐ No 2 Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

00033296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Road # A Glen Burnie MD Blob

Neil Padgett MD
31. Date filed (Month, Day, Year) 7711 Quarterfield

FEB 28

DHMH 17 Rev 1/2001

29c. License number

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a, any Injury or other traumatic event the Men Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner Division or Vital Records, P.O. Box 68760,

attending physician and for use as the burial-tran To the Hospital or Attending Physician: After this hours after death. within 24 hours after death To the Funeral Director:

				1 - For State Registrar	State of Mar			ent of Hea ate of De			jiene _{eg. No.} 20	07	08203
		Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) Wanda As Facility Name (If not institution, give:	Leeson		4b. C	ity, Town, or Lo	cation of Death	2. Date of Dear Month February	Day 27, 2	Year 2007 y of Death	3. Time of Death 2:18 P.M
180		Funeral Director		Homewood at Crumla 5. Social Security Number 409-48-4172 Usual Residence of Decedent		In yrs. last birt			Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep. 27	Year)	9. Birthp Coun Virg	olace (State or Foreign ntry) ginia
0D° 9		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show hy laying or other traumatic event, the Medical Examinating must be muitted at ance.	rai Director	10a. State 10b. County Maryland Frederich 10e. Street and Number 4303 Horine Court	ς	Oc. City, Town	10f.	Zip Code		1	Og. Citizen of United	What Coun	es
	-0036	hours after de ntural', or item	ed by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 15. Decadent's Edu	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates:		1 ☐ Yes		Specify:	ecify Yes or No- Rican, etc.)	Specii	ce-Americ ck, White, e	etc.
103	Baltimore, Maryland 21215-0036	filed within 72 Hygiene. other than "na ent, Ite Medic	e Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)	completed) College (1-4or 5+)			work done durii ruse retired)	ng most of work	ing e (First, Middle, M	OWT HO	me	austry
A 27	Marylan	12 should be h and Mental 7 is marked o traumatic eve	To Be	Walter Tate 19a Informant's Name/Relationship (Ty) Linda Sanbower / Da	•			Be Street and	elva Gar Number or Rura	dner	City or Town	, State, Zip	Code)
00:	imore, I	Pages 1 and ment of Healt ant: if item 2: ury or other t		20a. Method of Disposition 1 ② Burial 2 □ Cremation 3 ③ A 4 □ Donation 5 □ Other (Specify)	amoust from State	20b. Place of cemetery	Disposition (f	lame of r other place)	064000	h 3,	MD 217: 20c.Location airfax	- City or To	
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urda lessaga	3760,	The law requires that the death certificate be executed The has been signed by the attending physicien and By Shoult be detached for use as the burial-transit The law requires that the detached for use as the burial-transit The law requires that the detached for use as the burial-transit The law requires that the detached for use as the burial-transit The law requires that the death of the law requires that the law requirements the law requirements that the law requirements that the law requirements the law requirements the law requirements that the law requirements the law require	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o	r).	015	D.).	erse			Interval Between Onset and Death
08 W	P.O. Box 68	t the death certifice by the attending pt tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other					te of delive	ry Day Year
ciamas		w requires that been signed b should be deta	ρ	Part II. Other significant conditions con	tributing to death but n	ot resulting in	the underlying	g cause given in	Part I.	23e. Did tob			e cause of death? ably 4 Unknown
250	Vital Records,	ian: The law r rtificate has be stor, page 2 sh	Be Completed	25. Was case referred to medical	il			26	Place of Death	24a. Was ar autopsy perform 1 Yes 2	ned?	Were autop prior to com death? 1 ☐ Yes ;	osy findings available inpletion of cause of 2 No
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NOON	Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	ledical Certifi	4 Homicide determined 29a. Certifier Check only Medical Examin	28e. Place of Injury building, etc. (S ician: To the best of m er: On the basis of ex	Specify) ny knowledge, amination and	death occurre	ad at the time of	late and place	28f. Location (Str City or Town	, State)	annor as sta	nted
之		To the Vithin 2 Complete Complete	Med	29b. Signature and title of certifier 30. Name and address of person who cor	and manner stated		45	9c. License nu			Od. Date signe		
		Sta Registr		Casper Cline, M.D. 31. Date filed (Month, Day, Year) MAR 0 1 200	32 Segistrar's		treet,	Freder	ick, MD	21701	,	,	

State of Maryland / Department of Health and Mental Hygiene

1-	For Stata Registrar

Name known to pnysician: SEVINE, PATRICIA

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Certificate of Death

		1. Decedent's Name (First, Middle, Last,			Date of Death Month Day Year 3. Time of Death Year						
	ician dical	Pat	Patricia Levine							6:10	АМ
	niner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Death		4c. County	y of Death		
	Sp. 3	VA Maryland Health			Perry Po			Ceci			
Funer Direct		034-42-5676	7. Age (In yrs. 3 M 2⊠ F 52	last birthday, Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) Feb. 19,		9. Birthpi Coun Ne	lace (State or try) ew York	Foreign C
and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation				11	Od. Inside City	v Limits
Maryl faho	ŏ	Maryland		, .	Baltimor	re.				1.⊠Yes	
the 28a-	Director	10e. Street and Number	1		10f. Zip Code		100	ı. Citizen of	What Coun	try?	
h with	O E	315 North Charles	s Street		21		U.S.A.				
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Itama 23s or 28s-1 show sumatic avent, the Mcdical Exentine mast be notified at	Funeral	1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1½ Yes 2 ☐ No If Yes, Give		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2X No		ecrfy Yes or No- Rican, etc.)				
ural',	d by		Year or Dates: 1970	-79			Specif	y. WI	hite		
n 72 h	ete	15. Decedent's Edu (Specify only highest grad	cation e completed)	/ Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion Iring most of work	ing 16	ib. Kind of B	usiness/inc	dustry	
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be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
should tand Ment	ို		Levine				Emma Ake				
ges 1 and 2 should but of Health and Ment: If Itam 27 Is marked or other traumatic a	0	19a. Informant's Name/Relationship (Ty Roseann Kirby	pe, Print)	1	ng Address (Street ar North Chai					Code) 21203	1-43
ttam itam		20a. Method of Disposition			osition (Name of matory or other place)	1	Date 20	c. Location	- City or To	wn, State	
Pages iment of tant: If it jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovai from State	_	brest Cemete		07/07 Ow	ings	Mills	, Mary	land
permit. Page Department of Important: If any Injury or	SUC.	21. Signature of Funeral Service License	Ausnon	C. I	2. Name and Address Lee A. Patt Ecryville	terson &	Son Fune	ral H	ome, 1	P.A.	
*		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death							Approximate Interval Between	een
Physicia	n	Immediate Cause (Final disease or condition	MYOCARDIAI							Onset and De	eath
/Medica		resulting in death)	Due to (or as a consequ		RCITON					CINCINCAN	LV
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leath certificate be executed attending physician and I for use as the burial-transit	clan/Medical	in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de				ite of delive	,	ear		
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requires that the been signed by th hould be detache	by P	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	inderlying cause given	in Part I.	23e. Did tobac	co use con	tribute to th	e cause of de	alh?
= 47 0	ed	RHEUMATOID ARTHRI	IJS. HYPOTHYRO	DIDISM	, POST TRA	UMATIC	1 ☐ Yes	2 🗆 No	3 🗌 Proba	ably 4∑ÜUn	nknown
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The ete h page	NO.						performe	d?	death?	2 No	120 01
Physician: r this certific ral director,	Be (25. Was case referred to medical examiner?				26. Place of Death	Check only one			/-	
Physical this of all dire	2	1 ☐ Yes 2 🛣 No	ospital: 1 Inpatient 2	ER/Outpatier		4 Nursing Ho	me 5 Residenc	e 6 □Oth	er (Specify)	
Attending P or death. sctor: After the type the funeral	atlon:	27. Manner of Death XXNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	at es 2 □ No	28d. Describe how	injury occur	red		
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To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the time vestigation, in my opin	, date and place, nion, death occurr	and due to the caused at the time, date	se(s) and ma	anner as sta and due to	ated. the cause(s)	
o the	Me	29b. Signature and title of certifier			29c. License r	number	29d	Date signe	d (Month, L	Day, Year)	
FSFÖ		V Kan M. n.	m Xa	ab 21	D4072	3		2/15/0		-	
4		30. Name and address of person who co	mpleted cause of death (Item			3		./ LD/ U	/		
FIVA		Karithanom Isaac				e System	Perry F	oint,	MD :	21902	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR

2 2007

			1 - For State Registrar	State of	Marylar			nt of H te of L		nd Me	_	giene Reg. No:	007	08205
× 9	Physici /Medi		Decedent's Name (First, Middle, Last Eugene Lucas)						2	Date of De Month Februa	ath ary 28, 2	200 Ž ear	3. Time of Death 0800 A M
4	Examir		4a. Facility Name (If not institution, give 12101 Kemp Drive	street and numb	er)		4b. City		Location of rostbur				unty of Deat	h
	Funeral Director		217-20-3300	x 7. ZM 2□F	Age (In yrs.	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	4 Hrs. 8 Min.	Date of Bir (Month, Da July	th ly, <i>Year)</i> 07, 1934	9. Birt Mar	hplace (State or Foreign unitry) yland
	Maryland a-f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Allegany	7		y, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	al Director	10e. Street and Number 12101 Kern		.W.			p Code				10g. Citizer U.S.A.	g. Citizen of What Country? S.A.	
9036	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other then "naturel", or items 23s or 28s-f show eumatic event, the Medical Experiment rutal by notified at	d by Funeral	11. Marital Status 1 □ Never Married 212 Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? X No		Was Dece If Yes, spe 1 Yes	cify Cubai	spanic Origin, Mexican, I	n? (Speci Puerto Ri	fy Yes or No can, etc.)		4. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	filed within 72 h Hygiene. sther then "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 8 0		or 5+)	16a. Dece (Give life. mainte	kind of w DO NOT L	ork done d ise retired)	urina most c	ion 16b. Kind of Busines county court			of Business/	Industry
yland	should be filk ind Mental Hy is marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) George E. Lucas						Bernic		First, Middle,	, Maiden Su	mame)	
	교육등		19a. Informant's Name/Relationship (T) Bonita Lucas	урв, Print) wife	,	12101	Kemp	Drive,		Frost	burg	Mar	yland	21532
Baltimore,	00		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		ite C	Place of Dispo cometery, cres stburg Me	matory or	other place		March 0	e 2, 2007 I		ion - City or Ma	Town, State ryland
Ball	permit. Pag Depertment Important: I any njury o		21. Signature of Funeral Service Licens	Dur	t				Home,	57 Fro	st Ave.,	Frostbur	g, MD 2	21532
	Physician /Medical Examiner	ıer	23a. Part# Enter the disease, or complished, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or	BETT as a conseq	ES My juence of): SCUE	Eu.	TUS				P	SEASE	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Cause (Diseese or injury that initiated events resulting in death) Last		DENLIPEMIA s a consequence of):								10 years	
.O. Box 6	the death certific by the attending p ached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Feta t at time of d	death 3	Ectopic p					23d	. Date of deli Month	very Day Year
rds, P.	w requires that the de been signed by the a should be detached t	b	Part II. Other significant conditions col	ntributing to deat	h but not res	ulting in the u	nderlying	cause give	n in Part I.			obacco use Yes 2 🗆 N		the cause of death?
al Records,		Completed									1 Tes	2 No	death?	topsy findings available completion of cause of 2 No
t Vital	ysician: nis certifici director,	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	lospital: 1 ☐ Inp	atient 2	ER/Outpatier	nt 3 D	Othe			5 Resid	-	Other (Spec	cify)
Division of	tending Ph leath. tor: After th the funeral		27. Manner of leath 1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	м	28c. Injury Work 1 🗆 Y	at ? ′es 2∐No		d. Describe I	how injury o	ccurred	
N N	or Al	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At he etc. (Specif	ome, farm, str y)	eet, factor	y, office		281	Location (: City or Tox		um <i>ber</i> or Ru	ral Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	29a Certifier 13 Certifying Phy (Check only one)	ner: On the basi and manner	s of examina	wledge, death tion and/or in	h Schurtsc vestigation	n, in my op	date and inion, death	occurred	at the time,	causo(s) and date and pla	o manner as ice, and due	to the cause(s)
	To th To th comp	M	29b. Signature and title of certifier	7000	0 11.	4	29	c. License				29d. Date s	igned (Month	n, Day, Year)
	5		30. Name and address of person who co						0013			7	128	107
	n de Sta	te	31. Date filed (Month, Day, Year)	32. Reg	e) Gee Strar's Signa		1 48	THE	LN T	EM	LACE	- 172	ostau	71237
100	Registr	ar	MAR U 12	007	1.8.1	B. I	Grack	- 3						01052

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** Lucille Catherine bruary 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lions Center for Rehab & Ext. Care Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 02/04/1924 9. Birthplace *(State or Foreign Country)* Maryland **Funeral** Months Hours Days 1 □ M 2 🗓 F 83 218-12-5228 Director Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 540 N. First Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 X Widowed 4 ☐ Divorced White er than "natura , the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Operator Telephone Company 7 Is marked other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Stewart Ear1 Pearl Bessie Miller ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sherry Laurie / friend 21 Oak Terrace, LaVale, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If it any injury or o Hillcrest Mem. Park 02/22/2007 Cumberland, MD 4 ☐ Donation S Other (Specify) 21. Signature of Funer I Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, T.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician stage End disease or condition resulting in death) 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending physic I for use as the b 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No autopsy perform 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 XNatural 2 ☐ Accident 1 Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the I 29b. Signature and title of certifier 29c. License number 3 DOD ebruary 20, 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tarn Wonsoc Dhu 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Constantina Lafazanos Feb. 24, 2007 2:00p */Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Home Rockville Montgomery If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/22/1922 5. Social Security Number 1 Year Days Birthplace (State or Foreign Country) Funeral Hours Months 1 □ M 2 🔀 F 134-30-6908 84 Director Greece Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits show MD r 28a-f sh notified Montgomery 1 ☐ Yes 2 ☐ No Rockville **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 299 Hurley Avenue 20850 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2♥ No ò 1 ☐ Yes 2 ☑ No Specify 2 Specify: White 3 ☐ Widowed 4 ☑ Divorced 'natural", er than "nature , the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Seamstress Factory 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Theodore Lafazanos Stavroula Festas ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tracence. Nikolas Mechelis/Nephew 4109 Dana Court Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 2/27/2007 Silver Spring, Md f Funeral Service PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21. Signating 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stroke /Medical Due to (or as a consequence of): **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-tran Due to (or as a consequence of): Physician/Medical ası nse i IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Į0 in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 1∐ Yes 2 ₽ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: 1 ☐ Inpatient Other:

The law requires that the death certificate be executed Box 68760. P.O. | Division or Vital Records, certificate I or Attending Physician: after death. funeral director, Within 24 hours after occur.
To the Funeral Director: After

Baltimore, Maryland 21215-0036

Be P Certification:

Medical

State

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural 2 Accident

> (Check only one)

29a. Certifier

3 ☐ Suicide 4 Homicide

29b. Signature and title of certifier

5 ☐ Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? Injury М

2 ER/Outpatient 3 DOA

28b. Time of

1 Yes 2 No 28d. Describe how injury occurred

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Feb. 26, 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G.Thaker MD 31. Date filed (/

11125 Rockville Pike #208 Rockville, Md 20852

D43430

Registrar

	,	1 - For State Registrar	State of Maryla	and / Dep		lealth and	Mental Hy	/giene Reg. No.	-	08200			
Physic /Med Exami	cal	Decedent's Name (First, Middle, La IVa Lee McBee 4a. Facility Name (If not institution, giv Country House	e street and number)		4b. City, Town, or		2. Date of Domestin	1 0 4c.	07 County of Death				
Funeral Director		5. Social Security Number 6. S		s. last birthday)	Cumber	If Under 24 Hr Hours Mir		rth	lleghe 9. Birth Cou West	eny place (State or Foreign ntry) Virgini			
the Marylan 28a-f ehow	Funeral Director	Md. 10b. County Allegi 10c. Street and Number		City, Town or Loumber L				10d. Inside City L 1羟Yes 2[
ith with	alDi	15 Cumberland	Street		21502	2		U.S		ntry :			
and 21215-0036 be filed within 72 hours after death with the Maryland hial Hygiene. Ind other than "natural", or items 23a or 28a-1 ehow or other than "natural", or items 23a or 28a-1 ehow ovent, I'm Medical Exertifier must be invitiled at	þ	11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 140	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No to Rican, etc.)		4. Race - Americ Black, White, Specify: Wh				
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. The marked other than "natural", or traumatic event, Ita Medical Exami	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, emaker	ition uring most of wo	rking	16b. Kin	d of Business/In	dustry			
Maryland 212: 42 should be filed withir th and Mental Hygiene. 77 le marked other than traumatic event, ILA MA	To Be C	17. Father's Name (First, Middle, Last) Marvin C. Webe 19a. Informant's Name/Relationship (i	er	405 14 15		Flossie	me (First, Middle e Micha	el W	eber				
		Deborah Seldon		335	ng Address <i>(Str</i> ee <i>t a</i> Hawthorr	nd Number or R 1e Rd,	Keyser	er, City or , WV	Town, State, Zip. 26726	Code)			
Baltimore, M permit. Pages 1 and 2 Department of Health. important: It liem 271 any injury or other tre once.		20a. Method of Disposition N Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery, crer pohrs	sition (Name of natory or other place Cross Ro	oads 2		Ber		Springs,			
Balti permit. Departri importa any inju		21. Signature of Foneral Service Licensee 22. Name and Address of Facility Hunter-Anderson Funds 36 S.Green St., Berkeley Springs 23a Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
filtrate be executed // Medical Examiner // Medical Be executed // Examiner fransit style burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any leading to the extensions of the extension of the extensio	a. Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d.	quanee of):	L I	NEAR	TION).	Onset and Death SUDDEM			
the death cert y the attending	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23	d. Date of delive	ry Day Year			
I HECOTIAS, P. The law requires that ate has been signed by bage 2 should be deta	ted by P	Part II. Other significant conditions co	ntributing to death but not re			n in Part I.	UI.			e cause of death?			
VITAI KEC sician: The law r certificate has be lirector, page 2 sh		HTRIAL -	FBRILI	9710 A	/				prior to con death?	osy findings available npletion of cause of			
OI VICAL Physician: T this certificate ral director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	FB/Outpatient	0.1		th (Check only o		7015 (6				
E file		27. Manner of Death 1 Patural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 \(\text{Ye}		28d. Describe h)			
LIVISION To the Hospitel or Attending whith 24 hours after death. To the Funerel Director: After completely filled in by the tune		4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci	Ty)			City or Tow	m, State)	Number or Rurai				
• Hos	Medical	29a. Certifier 1 Certifying Phy cone) 1 Induction Example 2 Medical Example 2 Medica	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my opin	, date and place nion, death occu	and due to the c rred at the time, c	ause(s) ar date and pl	nd manner as sta lace, and due to	ated. the cause(s)			
To th within To th Compl		29b. Signature and title of certifier 30. Name and address of person who ca	Addison			number	H\$4	29d. Date s	signed (Month, E	Day, Year)			
Q		Dr. Shiv Khann	a, \$221 E.	Nat4or		way, L	avale,	Md 2	21502				
Star Registra		31. Date filed MARDAY. 5ea 2007	32 Registrar's Sign	ature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year March Paul Russell Mills 10:46 PM /Medical 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Hagerstown

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Washington County Hospital Washington 9. Birthplace 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) MD (Month, Day, Year) February 15,1938 1**∑**M 2□F Months Director 214-46-5343 69 Yrs Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 X No Washington Big Pool 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13020 Indian Springs Road Funeral <u> 21711</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Heavy Equipment Operator Mills Excavating 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Russell Mills ပ Vergie Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Revell/Caregiver 13129 Pecktonville Road Big Pool, MD 21711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shankstown Cemetery 103/09/07 Big Pool, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street MO1414 Grove Funeral Home, P.A. Hancock, MD 21750-0368 WIS Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Jmill Lell /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a pleasur unince Examine Box 68760, Sydeath certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) Day Year ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pe 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy After this certificate perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

MAR 1 5

31. Date filed (Month, Day, Year)

- hulim

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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3.7.07

			1 - For State Registrar	State of M	faryland / Depa	artment of F			giene	08210
Ī	Physici		Decedent's Name (First, Middle Willard	_{e, Last)} Mahanes				2. Date of Dea Month Februal	Day Year	3. Time of Death 3:00A M
П	/Medic Examir		4a. Fecility Name (If not institution			4b. City, Town, o	r Location of Dea		4c. County of Dea	
			Westminster Nur 5. Social Security Number		b. Center	Wes	tminster		Carı	
	Funeral Director		223-38-2656	1 ½ M 2□ F	82 Yrs.	Months Days	Hours Mir		Year) Vii	thplace (State or Foreign ountry) ginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f ahow prount be notified at	tor	Maryland Car	roll	\ \	lestminste	er			1 ☐ Yes 2 📉 No
	or 284	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	eath v	Funeral	501 Hillside	12. Was Deceden	at Ever in U.S. 13		21157	Sanctu Ves or No.	U.S./	
	172 hours after death with the Marylar "natural", or liama 23a or 28a-f show idical Examinar must ke notilited at		1 ☐ Never Married 2 Marr	Armed Forces] No	If Yes, specify Cuba 1 ☐ Yes 2 XX No	an, Mexican, Pue	Specify Yes or No- into Rican, etc.)	Black, Whi	
2-003e	72 hours natural', dical Exi	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1944-46	dent's Usual Occup			16b. Kind of Business	White
213	within 72 ene. than nat he Madica	Completed		st grade completed) College (1-4or	(Give	kind of work done of DO NOT use retired	during most of w		hardware s	tore/ lawn&
7	iled wi Hygien thar th nt, th		12 17. Father's Name (First, Middle,	l ast)	parts	dept. cle		esman	garden equ	ipment
la la	And be for the formal for the formal for the formal for the formal for the formal form	To Be	Samuel Timot					Broadhea	,	
	12 should and Men is marka raumatic		19a. Informant's Name/Relations						r, City or Town, State,	Zip Code)
a)	iges 1 and it of Health if Itam 27 or other t		Mabel L. Mahane 20a. Method of Disposition	s/ wite	20b. Place of Dispo	Box 823		inster, M	1D 21158 20c. Location - City or	Town, State
III O	Pages nent of ant: If I		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Pipe Cree	matory or other place k Cemeter	- 1	/2007	nr. Linwoo	d. MD
Dail	permit. Page Department o Important: If any njury or once.		21. Signature of Funeral Service	Licensee	500 - 20	2. Name and Addres	ss of Facility H	artzler F	uneral Hom	е
		0.0	23a. Part1. Enter the disease, or	complications that cause	the death. Do not ent	10 Church er the mode of dyin	o such as cardia	ac or respiratory arr	or, MD 217 est,	Approximate
F	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	Per ana	e elas a	cerl	ent		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	equence of):	A	4	0 0	Usene	1000
		Je.	Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a:	s a consequence ot):	plu /	aseu	Mu D	hene	25 92
	cate be executed by sicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dua to for a	s a consequence of):	······································				
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	by the ached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of death 5	Other (specify)				
,	ine law requires that the death tie has been signed by the atter page 2 should be detached for u	Ď	Part II. Other significant condition	ns contributing to death	but not resulting in the u	nderlying cause give	en in Part I.		bacco use contribute to	
Spros	v requi	eted	1					1 □ Yo	1	robably 4 Unknown
ב	the lay	Completed						autops perform	y prior to	utopsy findings available completion of cause of
ָ בּ	cian: entifica ector. p	Be C	25. Was case referred to medical examiner?	-				eath Check only on		2 140
5 2	r this c	. To	1 ☐ Yes 2 € No 27. Manner of Death	Hospital: 1 Inpati			4 Ki Mursing		ence 6 Other (Spe	cify)
	aath. or: Afte	ation	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	ation	ay Year) Injury	28c, Injury Work M 1 []	k? Yes 2 □ No		,	
	to this mostled in the law within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could a 4 ☐ Homicide determ	ined 286. Place of In	njury - At home, farm, str atc. (Specify)	eet, tactory, office		28f. Location (St City or Town	reet and Number or Ri n, State)	ural Route Number,
	hours hours uneral ly filled		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the best	t of my knowledge, death	occurred at the tim	ne, date and place	e, and due to the c	ause(s) and manner as	stated.
:	thin 24 tha F	Medical	one) 29b. Signature and title of certifier	Examiner: On the basis of and manner st	tated.	29c. License				
ı	11) 4	mille	Em 1	'T 5	TUVO	2	9d. Da e signed (Mont	., Jay, 18aij
	Mas		30. Name and Press of person	who completed cause of	death (Item 23a) (Type,	Print)	כדוי	Λ	1661	con
9	Sta	10	31. Date file (Month, Day, Year)	middleto	n m D C, trar's Signature	88 Poole	KK, U	Vestma	ister, MI	11157
	Registr	_	MAR O	2 2007	aus It 1	Couls 1	effe.		E2	

1

To Be Completed by Funeral Director

Physician /Medical

Examiner

Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

	pe or Print State of Mar							egible.	
1 - For State Registrar	a.o oi ividi			e of Dea		, ,	Reg. No.	007	00211
Decedent's Name (First, Middle, Last)						2. Date of Dea Month	-	Year	3. Time of Death
BEVERLY MELVIN						FEBRUAL	RY 26	, 2007	2:48A. ^M
4a. Facility Name (If not institution, give str			4b. City,	Town, or Locat	_			Ounty of Death	
5. Social Security Number 6. Sex		In yrs. last birthda			nder 24 Hrs.	8. Date of Birth	h	NCE GEO	place (State or Foreign
578-76-3974 1 ¹	1 2 € F	50 Yrs.	Months	Days Hou	ırs Min.	MARCH 2			HINGTON, D.C.
Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or	Location						10d. Inside City Limits
MD PRINCE GEO	RGE'S	CAPITOL	HEIGH	ITS					1 ☐ Yes 2 ☐ No
10e. Street and Number 6103 L ST.,			10f. Zip	Code 1743				en of What Cou	
11. Marital Status	. Was Decedent Ev Armed Forces?	er in U.S.	3. Was Deced	dent of Hispanio	c Origin? (Special	ecify Yes or No- Rican, etc.)	. 14	4. Race - Amer Black, White	
1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes			, ,		Specify: BL	
3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educa	Year or Dates:		cedent's Usua				16b. Kind	d of Business/I	ndustry
(Specify only highest grade of Elementary/Secondary (0-12)		ı (Gi		rk done during	most of work	ing			
12th					MESTIC			DME CAR	E
17. Father's Name (First, Middle, Last) RAYMOND WASHINGTO	N					e (First, Middle, GAINES	Maiden S	iurname)	
19a. Informant's Name/Relationship (Type BERNON WASHINGTON				(Street and No RUN DR.		al Route Numbe		Town, State, Z 20735	ip Code)
20a. Method of Disposition 1	noval from State		rrematory or o	ther place)		Date		ation - City or	
4 ☐ Donation 5 ☐ Other (Specify)		MT. OLIV	ET CEM		3/5	/07		HINGTON	
21. Signature of Funeral Service Licensee	n Sal	ley		d Address of F IARYLAN	,	, N.E. 1		TOL MO.	
23a. Part1. Enter the dise se or complica shock, or heart failure ist only one immediate Cause (Final disease or condition resulting in death)		consequence of):	-	e of dying, suc		or respiratory ar	rest,		Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. East Unserving Cause (Disease or injury that initiated events resulting in death) Last		consequence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	c. If yes, outcome pf 1□Live birth 2 4□Pregnant at ti	Fetal death	3□Ectopic pr 5□ Other <i>(sp</i>				23	3d. Date of deli Month	very Day Year
Part II. Other significant conditions contr	ibuting to death but	not resulting in the	e underlying c	ause given in F	Part I.	23e. Did to			the cause of death?
Acrite Lenal 1	がルフト	6045	nlopati	7		101	∕es 2□]No 3□Pr	obably 4 Únknown
Hypertalemia	monia	Seren	. Met	bulk as	Cicolo		rmed?	24b. Were au prior to death?	topsy findings available completion of cause of
25. Was case referred to medical				26. F	Place of Deat	1 Yes h (Check only o	2 X No ne)	ı 🗆 Tes	2)(C) No
examiner? 1 Yes No	spital: 1 npatient				Nursing Ho	ome 5 Resid	dence 6	□Other (Spec	cify)
27. Manner of Death 1 □XNatural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	e of 2	28c. Injury at Work? 1 ☐ Yes		28d. Describe h	now injury	occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	/ - At home, farm, (Specify)	street, factory	y, office		28f. Location (8 City or Tox		Number or Ru	ral Route Number,
29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine		xamination and/or							
29b. Signature and title of certifier			290	c. License num				signed (Montl	
1500 1	v D			D006	480		Z	126/0	7

State

Registrar

7503 SURRANTS RD. CLINTON, MD.

20735

30. Name and address of town who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 0 2 2007

(wel

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,		epartment of Health and I Certificate of Death	Mental Hygie Reg.	7 11 1	08212
-	Physici /Medic		1. Decedent's Name (First, Middle, Last) ERIC MC Koy		2. Date of Death Month	Day Year 2.7	3. Time of Death
	Funeral Director	er	4a. Facility Name (If not institution, give street and number) $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. or Location	8. Date of Birth	4c. County of Death 9. Birthple Count 1970 WASHIN	ace (State or Foreign ry) NGTON, D.C.
	with the Ma a or 28a-f s	Director	10e. Street and Number 4281 6th St., S.E. #202	10f. Zip Code 20032	"	. Citizen of What Count JNITED STAT	•
336	be filed within 72 hours after death with the Maryland tital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ⚠No Specify:		14. Race - America Black, White, e	an Indian, etc.
1215-0036	within 72 hou iene. • than "natura the Medical E	Completed	15. Decedent's Education 16a, D	ecedent's Usual Occupation Give kind of work done during most of wor ife. DO NOT use retired) BUS DRIVER	king	b. Kind of Business/Inde	ustry
Maryland 2		To Be Co	17. Father's Name (<i>First, Middle, Last</i>) JOHN LOVE	18. Mother's Nam	ne (First, Middle, Mai NE McKOY		
	ges 1 and 2 should t of Heatth and Mei If ttem 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) 19b. N VENTSENE LOVE/MOTHER 420	Mailing Address (Street and Number or Ru 81 6th St., S.E. #2	ral Route Number, C 02 WASHIN	NGTON, State, Zip o	20032
Baltimore,	Pages 1 tment of He tant: If Iten jury or oth		1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT • OL	isposition (Name of crematory or other place) IVET CEMETERY 3-3-		c. Location - City or Tov ASHINGTON,	
Ба	permit. Page Department of Important: If any Injury or once.	13 75	21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	22. Name and Address of Facility CAPITOL MORTUARY 1			:E: wash.,
68760,	Physician // Medical Examiner is the burial-transit	edical Examiner		Approximate Interval Between Onset and Death			
P.O. Box 6	eath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	y Day Year
	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		co use contribute to the	
VITAI Records,	aw is b	Completed			24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of 2 No
1	rsiciar s certif lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outp.	Other:	th (Check only one)	. □	
IVISION OF	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: To	27. Manny of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ne of 28c. Injury at	28d. Describe how	e 6 □Other (Specify) injury occurred	
	ital or Atte ins after de ral Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)		City or Town, S		
	he Hosp in 24 hou he Fune pletely fi	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my knowledge, to the basis of examination and/and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as state and place, and due to	ited. the cause(s)
i	To t To t	Ž	29b. Signature and title of certifier	29c. License number 1344176435W17		Date signed (Month, D	ay, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Ty ETHEL WEID 4526 KESWICK RD. B				
	Sta Registr	700	31. Date filed (Month, Day, Year) ARR 0 2 2007 32. Registrar's Signature	1,110			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 02-26-2007 Year **Physician** 2254P MITCHELL WILLIAM A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Calvert <u>Calvert Memorial Hospital</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 06-25-1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**⅓**M 2□F Hours Yrs. Alex., Va. 579-34**-**3725 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23s or 28s-f show event, I'm Medical Examinar must be notified at 1 Pryes 2 No Directo New Carrollton Maryland Prince George's 10e. Street and Number 10g. Citizen of What Country? 20784 6004 Mentana Street U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ₩ No Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10th College (1-4or 5+) Рерсо Overhead Lineman permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othn any Injury or other traumatic event, gonce. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Blake Grace Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William S. Mitchell/son 3385 Ferry Landing Road Dunkirk, Maryland 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State 03-03-2007 Cedar Hill Cemetery Suitland, Maryland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cedar Hill FH 4111 PA Ave. Suitland, Md. 20746 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CIMMA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 18 Yes 2 No 3 Probably 4 Unknown as been signal Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page this certificate Pes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 [31npatient ပ 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DŎA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 🗱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 t To the Fu 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 02-28-2007 D13339 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8824 Cunningham Drive Greenbelt, Md. 20740 Tsunie Chan-Chien, MD MAR 0 2 2007 32. Registrar's Signature State Registrar

			F		State of M							ental Hv		-		
	1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death												08	2 4		
	Physici	an	Decedent's Name (First, Middle, Last) 2. Date of Death									v Year	3. Time	of Death		
	/Medi	cal	ERNEST			CDON	IALD					FEB.		200 ^{Year}	8:4	5 a ^M
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	Funeral		5. Social Security Number	6. Sex	7. A		(EHAB . last birthday)	If Unde	r 1 Year	WASH If Under a				RINCE 9. Bir	tholace (State	
j.	Director		127-07-4853	1[2	K M 2□F	. 8	8 Yrs.	Months	Days	Hours	Min,	8. Date of Bin (Month, Da 07-13-	191	8 NE	JERS	SEY
	fand		Usual Residence of Decedent 10a. State 10b. Count	ty		10c. Cit	ty, Town or Lo	ocation							10d. Inside	City Limits
	Mary B-f eh	tor	MD PRIN	CE (GEORGES	CL	INTON								¥□Ye	s 2 No
	within 72 hours after death with the Maryland ane. than "natural", or iteme 23s or 28s-1 ehow is Madical Examinar must be multisd at	Dire	10e. Street and Number					10f. Zi	p Code				10g. Cit	izen of What C	ountry?	
		Funeral Director	8600 MIKE					14/	207			-7. W		J.S.A.		
10	fter d	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Marned 1 □ Never Married 2 □ Marned 1 □ Never Married 2 □ Marned 1 □ Never Married 2 □ Marned 1 □ Yes, Give 1 0 1 0 0 0 1 □ Yes 2 □ No 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							14. Race - Am- Black, Whi						
036	ral', or	Completed by	3 ☐ 3 ☐ Widowed 4 ※ Divorced If Yes, Give 1940 7							Specify: B	LACK					
21215-0036	"natu		15. Decede (Specify only high	nt's Educ	cation completed)		16a. Dece (Give	kind of wo	ork done d	durina most	of workir	ng	16b. K	ind of Business	/Industry	
12	withir iene. than	dwo	Elementary/Secondary (0-12)		College (1-4or	5+)		DO NOTU AIL		•			11 9	. Post	דקקט יו	CE
	e filed al Hyg other	To Be C	17. Father's Name (First, Middle	, Last)			111		Critti		r's Name	(First, Middle,			1 0111	. СЦ
ylaı	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iteme 23a or 28a-1 show apprintury or other traumatic event, the Madical Examinat must be notified at ance.		ERNEST A. McDONALD LUELLA VAUGH								AUGHN					
Maryland			19a. Informant's Name/Relation		,									or Town, State,	_	
			MARIE R. CUR 20a. Method of Disposition	115	- SIST	20b. F	Place of Dispo	sition (Na.	me of	1		., CAE		L HEI		1D
Baltimore,	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (emoval from State		emetery, crei VERDA.				3-0	5-2007		VERDAI)
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B)	90 E # 9	. 2	honald	Oc	II Jus									WASH.		
	es that the death certificate be executed Ex Specificate by the attending physician and be detached for use as the burial-transit The detached for use as the burial-transit be detached for use as the burial-transit be detached for use as the burial-transit be detached for use as the burial-transit be detached for use as the burial-transit burial-		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death													
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384		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										The same			
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Division of Vital Records,	Physician: this certificaral director, p		25. Was case referred to medical examiner? 1 Yes 2 No	Leavitel.												
	ig Phy ter this neral o	-	Telephone Services Se									city)				
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	the Hospital or nin 24 hours afte the Funeral Dir npletely filled in		29a. Certifier (Chapter with a control of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	he Ho in 24 h he Fu pletely	edical	(Check only 2 Medica one)	l Examin	er: On the basis of and manner s	of examina	tion and/or inv	estigation	, in my op	oinion, death	h occurre	d at the time, o	date and	place, and due	to the cause((s)
	To the within 2	Σ	29b. Signature and title of certific	ər				290	c. License	number				e signed (Mont		
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0A	- ye		30. Name and address of person DR. LAXMI N. BERWA						101 a	INION.	MARY	LAND 20°	735			
77.00	Sta		31. Date filed (Month, Day, Year		32. Regist	rar's Signa	ture									
20.4	Registr	ar	MAR 0 2 2007	1244	my It.	Apre										

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Eugene D. Morton, Jr. February 24, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1**⊠**M 2□F Director 89 452-14-9272 November 5, 1917 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Directo Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 15310 Pine Orchard Drive, #1A Funeral 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Civil Engineering 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Eugene D. Morton Rosa M. Chatham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Barry E. Morton - Son 9126 Belvedere Drive, Frederick, Maryland 21704 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial Park & 20a. Method of Disposition 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/1/2007 Rockville, Maryland Menorah Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an has e 2 autopsy perform certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 2 ☐ ER/Outpatient 3 ☐ DCA 1 Inpatient P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

24, 2007

February

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

MINVIES

HOUZ

30

1 ☐ Yes 2 No

Texas

White

5:20 p M

State Registra

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 0 1 2007

M.D.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grot, M.D.

29a. Certifier (Check only one)

DHMH 17 Rev 1/2001

24 hours a

29c. License number

18101 Prince Philip Driv, Olney, MD

0 FF8 200 CI

			1 - For State Registrar	State o	f Marylaı	nd / Depa <i>Ce</i> a	artmen <i>rtificat</i>					giene Reg. No.	The same of the sa	08216	
Sit	Physici /Medi		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year										3. Time of Death 7 8:15 P M		
	Examir		4a. Facility Name (If not institution CollingsWood N		4b. City, Town, or Location of Death Rockville					4c. County of Death Montgomery					
	Funeral Director		5. Social Security Number 030-09-4516	6. Sex 1∭ M 2□ F		. last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 01/10/	th y, Year)	9. Birth	nplace (State or Foreign untry)	
	aryland show	Ļ	Usual Residence of Decedent 10a. State 10b. County			ity, Town or Lo								10d. Inside City Limits	
	vith the Ma	Directo	MD Mont 10e. Street and Number 6104 Robinwood	ethesda	10f. Zip Code 10g						1 □X/es 2 □ No g. Citizen of What Country? United States				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment if I liem 27 is marked other then "natural", or items 23s or 28s-f show eny injury or other treumsite event, the Medical Exacting transition at other.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:								Specify Yes or No- 14. Race - A			ican Indian,	
		To Be Completed t	15. Deceden (Specify only highe. Elementary/Secondary (0-12)	16a. Dece	**						6b. Kind of Business/Industry				
			17. Father's Name (First, Middle,			Scie	ntist	: / F		er's Name	(First, Middle,	Maiden :	ivate Bi Sumame)	usiness	
			Julius Mitchell Fannie Ganzburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
			Jason Mitchell - Son 3 Climbing Rose Court Rockville MD 20850 20a. Method of Disposition 1 Paurial 2 Cremation 3 Removal from State 1 Paurial 2 Cremation 3 Removal from State King David Memorial 20b. Place of Disposition (Name of cometer), crematory or other place) King David Memorial												
Baltir			King David Memorial 2/27/07 Falls Chuch, VA 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852												
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE TO THRIVE												
vision of Vital Records, P.O. Box 68760,	death certificate be executed to the attending physician and mod for use as the burial-transit of	ner	Due to (or as a consequence of): CARDTOMYOPATHY												
		dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence of):										
		by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Da 1 Yes 2 No 9 Unknown 23d. Date of delivery Month Da 23d. Date of delivery												
	ires tha signed I be de	Completed by Ph											the cause of death?		
	Attanding Physicien: The r death. •ctor: After this certificate h by the funeral director, page		25. Was case referred to medical examiner? 26. Place of Death Check only one									SV	prior to completion of cause of ed?		
		To Be											ce 6		
			27. Manner of Death 1	g (Monti	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Nort* M 1 □ Y					2	28d. Describe how injury occurred				
		Certification:	3 Suicide 6 Could a 4 Homicide determ	City or 1					(Street and Number or Rural Route Number, own, State)						
	9 4 2 9 9 9 9 4 9 9 9 9 9 9 9 9 9 9 9 9	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician : To the Examiner: On the ba and mann	best of my kno sis of examina er stated.	owledge, death ation and/or inv	occurred a restigation,	at the time in my opi	e, date and inion, deat	d place, a th occurre	nd due to the o d at the time, o	cause(s) a date and p	and manner as s place, and due t	stated. o the cause(s)	
)	within 2 To the	M	29b. Signature and title of sertifications		29c. License number 00067435					2 27 200 7					
			30. Name and address of person SAYED ELSAYYAD					IVE,	ROCK	VILL	E, MARY	LAND	20850		
ı	Sta Registr	_	31. Date filed (Month, Day, Year)	2007	gistrar's Signa										

			1 - For State Registrar	State of	Marylar			nt of H te of L		nd M	lental Hy	giene	07	08217
	Physici /Medi		1. Decedent's Name (First, Middle, BESS)		YAR	?co					2. Date of De.		4. Zo	3. Time of Death
	Examir	201	4a. Facility Name (If not institution, Hebrew Home of G	give street and numb reater Was	er) hingto	on	4b. City	Town, or ockvi	Location of	f Death		4c. Count	y of Deal	omery
	Funeral Director		115-38-9041	6. Sex 7. 1 □ M 2 🛣 F	Age (In yrs. 95	iast birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day 11/6/1]	h y, Year) L	Co	thplace (State or Foreign buntry) SSIA
	ed at	,	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside City Limits
	or 28a-f	Director	Md. Montgo		Roc	kville	10f. Z	p Code				10g. Citizen of	What Co	1 ¬Yes 2 No ountry?
	23a		6111 Montrose Ro	1.				2085	2			US	ì	
9800	ours after death with the Maryla ral', or Items 23a or 28a-f ehov Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ⊠No		Was Dece f Yes, spe 1 Yes	ecify Cubar	spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	ocify Yes or No- Rican, etc.)	Bla	ace - Ame ack, White ify: Wh	
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Ind Mental Hygiene. In marked other then "natural", or Items 23e or 28e-f show umatic event, ite Medical Energinal result be rediffied at	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		or 5+)	life.	kind of w DO NOT I		urina most	of workii	ng	16b. Kind of Business/Industry Own Home		
Maryland 2		To Be C	17. Father's Name (First, Middle, L Meyer Letven	ast)						's Name	(First, Middle, Barr	Maiden Suma	me)	
	27 th		19a. Informant's Name/Relationshi Leonard J. Marc								Route Numberckville			
altimore,	permit. Pages 1 ar Department of Hea Important: If Item any injury or other once.		20a. Method of Disposition 1x□ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			Place of Dispo cemetery, crem th Davi	natory or	other place			ate) 7]	20c. Location Elmont ,		Town, State
Balt	Departi Departi Imports any inj		21. Signature of Funeral Service L	censee	/			_			l Direc		d. 2	0852
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	omplications that cau nly one cause on each	sed the deat h line. ERIV				such as o			rest,		Approximate Interval Between Onset and Death
E	/Medical Examiner		Sequentially list conditions	5E1	as a consec VILE	E DE	5Mt	FNT	114					
	and I-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq									
8760,	cate be executed physicien and the burial-transit	dical		d	uo u oonooq									
Ö	it the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Feta tat time of d	al death 3 [Ectopic p	regnancy oecify)					ate of deli onth	ivery Day Year
₾.	es tha igned be de	þ	Part II. Other significant condition	s contributing to deat	h but not res	ulting in the ur	derlying	cause give	n in Part I.		23e. Did to	. /		the cause of death?
l Rec	The law ate has b page 2 sl	Completed									24a. Was a autop: perfor	med?	Were au prior to death?	topsy findings available completion of cause of
Vital	stcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place o	of Death	Check only or	18)		
2	£ 28	7	1 ☐ Yes 2 DNo	Hospital: 1 Inpa	atient 2	ER/Outpatien	3 D	Dthei	4 Murs	sing Hon	ne 5□ Resid	ence 6 □Oti	her (Spec	cifv)
			27. Manner of Death	28a. Date of I (Month,	njury Day Year)	28b. Time of		28c. Injury Work			8d. Describe h			
0	nding th: T: After e funer	at lo	1 ②Natural 5 ☐ Pending 2 ☐ Accident investiga		Day 1 Gai)	Injury	М		es 2 □ N	0				
É	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could no determin		Injury - At he etc. (Specif	ome, farm, stre (y)	et, factor	y, office		2	8f. Location (S City or Tow	treet and Num n, State)	ber or Ru	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be caminer: On the basis and manner	or examina	owledge, death ation and/or inv	occurred	at the time	e, date and nion, death	place, a occurre	nd due to the co	ause(s) and m late and place,	anner as and due	stated. to the cause(s)
	To the To the To the Comple	Σ	29b. Signature and title of certifier	Holes	my	HD.		c. License		130	5 4	19d. Date signe EBRU	d (Month	n, Day, Year) Y 24, 2007
			Dauleur 30 Name and address of person with the party of	no completed cause of	d (Item	п 23a) (Туре, I И.D. С	Print)	1 Me	ONTER	DSE.	ROAD,	RockVI	ILLE	MD 20852
	Sta Registr	te	31. Date filed (Month, Day, Year)	107 Regi	strar's Signa	ture de	ري							0-33-7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Beath 25 Day 0^{Year} 02Month Physician JOHN MCKENZIE FRANCIS 10:25A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY WMHS BRADDOCK CAMPUS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 M 2 □ F 218-50-0132 60 Director February 22, 1947 Usual Residence of Decedent 10c, City, Town or Location 10a, State 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Allegany Frostburg the 10e. Street and Number 10031 Piney Mountain Road, S.W. 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗚 No Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) attendant gas station 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Frederick McKenzie Margaret Bowers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McKenzie wife 10031 Piney Mountain Road Frostburg Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of important: If it any injury or o once, Nation 3 ☐ Removal from State Maryland Saint Michael's Cemetery 4 Donation 5 Dother (Specify) February 28, 2007 Frostburg 21. Signature of Funeral Service Licens 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYUCARDIAL INFARCTION disease or condition resulting in death) ONE HOUR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the 88 attending properties of the second se 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a detached f O 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an has autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 🔲 Inpatient 2 XER/Outpatient 3 □ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred i or Attending Fafter death. 1 Natural 5 Pending investigation Injury. after death.

Director: After in by the further. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai the Funeral 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 033417 (MARTIMA) FLEBRUARY 25, 2007 5

DHMH 17 Rev 1/2001

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Registrar

1068 NATIONAL INGINAY

21502

MARYLIND

LAUNCE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32 Registrar's Signature

MOEN

AMESA

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 42 Shirley Ann McPeak FEBRUAR 27 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTED BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Dec. 25, 1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F 500-40-5925 Míssouri Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Cecil 1 XYes 2 No Perryville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 428 Harford Street 21903 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Tes 2 X If Yes, Give Year or Dates: 1 Never Married 2X Married 2 🔀 No 1 ☐ Yes 2 ☒ No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) V.A. Medical Center Elementary/Secondary (0-12) College (1-4or 5+) Perry Point, Maryland Twelve Years Dietetics Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roscoe Edwards Illa Wiggins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond J. McPeak, Jr. 428 Harford Street, Perryville, Maryland 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State Brookview Cemetery 4 □ Donation 5 □ Other (Specify) 03/07/07 Rising Sun, Maryland 21. Signafure of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, larger than the control of th Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS -DAYS disease or condition resulting in death) Due to (or as a consequence of): PULMONARY DISEASE OF UNKNOWN ETIOLOGY 3 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery lonth Year Dav tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No her (Specify)

Physician /Medical **Examiner** physician and the burial-transit Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Examine Physician/Medical as asn for signed by the a d be detached for cate has been sig , page 2 should b certificate I director this After n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

"natural", or items 23a or

event, the Medical Examiner must be

with

death 1

filed within 72 |

Pages 1 and 2 should be

Hygiene.

Department of Health and Mental Hygic Important: If item 27 Is marked other any Injury or other traumatic event, IL once,

Maryland 21215-003

Baltimore,

notified at

Director

Funeral

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Completed

Be

2

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)	
Part II. Other significant conditions	contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use con
			24a. Was an autopsy performed2-1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of Deat	th (Check only one)
1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	ome 5 ☐ Residence 6 ☐ Otl
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occur

Be Completed by Certification: To

Medical

6 Could not be determined 3 Suicide 4 Homicide

2

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) RES-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTORN AVENUE BALTIMORE, MD 21224 POSSNER mb 4940 ADAM 31. Date filed (Month Day, Registrar's Signature Year)

State Registrar

completely

within 2.

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DHMH 17 Rev 1/2001

To the Hospital or Attending

Certificate of Death

Physicia /Medica Examine										
Funeral Director										
land ow it										

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 X M 2 □ F Yrs 117-12-9605 90 June 13, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f sho Examiner must be notified a Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 9709 Kentsdale Dr. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must any lujury or other traumatic event, the Medical Examiner must once. 20854 by Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ∐ Yes 2 ZXNo If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electronic Engineer 17. Father's Name (First, Middle, Last) Be Vartan Margosian Estella Bakalian 19a. Informant's Name/Relationship (Type. Print) Alice E. Margosian / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) National Crematory 3-5-2007 21. Signature of Funeral Service License Willco 23a. Part1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Atherosclerotic Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ Hypertension Completed Hyperlipidemia 24a. Was an 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number MD15901 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Grady, MD 4201 Cathedral Ave. N.W. # 114 31. Date filed (Month, Day, Year) FEB 2 8 2007 Registrar's Signature State Registra

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 23, 7:50 John W. Feb. 2007 Margosian A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9709 Kentsdale Dr. Montgomery Potomac If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 1916 New York 10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian Black, White, etc. Specify. White 16b. Kind of Business/Industry <u>Litton Industries</u> 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9709 Kentsdale Dr. Potomac, Maryland 20854 20c. Location - City or Town, State Falls Church, Va. 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Washington D.C. 20016 Approximate Interval Between Onset and Death minutes years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Feb. 26, 2007

Registrar

DHMH 17 Rev 1/2001

MAR 0 2 2007

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		1 - For State Registrar	State of N	naryianu		artment of rtificate of		ina ivie		giene Reg. No.	print with the server	
Dhusi		1. Decedent's Name (First, Midd	le, Last)		-			2	2. Date of De Month	ath (2007	3. Time of Death
Physi /Med		Nadia Naydich						F	February	Day 7 23, 2	Year 2007	8:30 p ^M
Exam		4a. Facility Name (If not institution	n, give street and numbe	r)		4b. City, Town,	or Location of	f Death		4c. C	County of Death	*
	, S	6204 Lone Oak Dri				Bethesda	-			Mo	ontgomery	
Funera Directo		5. Social Security Number 213-31-3051	6. Sex 7. A	Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min.	B. Date of Bird (Month, Da October	y, Year)	Cour	* /
and w		Usual Residence of Decedent 10a. State 10b. Count	,	10c City.	Town or Lo	cation						Ind Incide City I legite
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leath with the Marylar ns 23a or 28a-f show must be notified at										Tog. Citize	en of What Cour	iny:
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ter o	by Funeral	1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	Armed Forces ried 1 ☐ Yes 2 ☑ If Yes Give	s?] No	1	Was Decedent of f Yes, specify Cul I ☐ Yes 2xx No		Puerto Ri	can, etc.)		Black, White, Specify:	etc.
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Z1Z15-0U36 d within 72 hours af giene. er than "natural", or the Medical Exami	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or	(51)	(Give life. L	kind of work <mark>don</mark> e DO NOT use retire	during most ed)	of working	' ']			
nd 2121 e filed within al Hygiene. other than '	ĕ		5+	34)	Ent	omologist				G	Government	
of High	Be (17. Father's Name (First, Middle	Last)				18. Mother	's Name (I	First, Middle,	Maiden S	Surname)	
Ments wents rrked	10	Leonid Naydich					Esthe	er He	nven			
Maryland Id 2 should be file Ith and Mental Hy 27 is marked othe		19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailin	g Address (Stree	and Number	r or Rural I	Route Numbe	er, City or	Town, State, Zip	Code)
and 2 and 2 allth 27 i		Yelena Nusinovich / Daughter 6204 Lone Oak Drive, Bethesda, Maryland									817	
of He fiter		20a. Method of Disposition	0 T P	20b. Plac	e of Disponetery, cren	sition (Name of natory or other pla	ice)	Dat			ation - City or To	own, State
Pag nent ant: I		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (⁶		Cemetery		/25/20	07	Adeln	hi. Maryl	and
Datimore, INarylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic er annea.		21. Signature of Funeral Service	Licensee		22 Hin	Name and Addr es-Rinaldi	ess of Facility Funera	1 Home	. Inc.			
		23a. Part1. Enter the disease, o	r complications that cause	ed the death.	LL8 Do not ente	OO New Harr	pshire A	Avenue	, Silve	r Spri	ng, Maryl	and 20904 Approximate
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Cancer of the Educreos										Interval Between Onset and Death 3 Years
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uted	l in	cause. Enter Underlying Cause (Dissass or injury that initiated events	S									
e exec an an rial-tr	Examiner	resulting in death) Last	Due to (or a	s a consequen	ice of):							
oo / ou, tificate be executed g physician and as the burial-transit	ledical		d									
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the death cer y the attendin	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√☐ No 9 ☐ Unknown		e pt pregnancy 2 Fetal de at time of deat	eath 3	Ectopic pregnand Other (specify) _	у			23	d. Date of delive Month	ery Day Year
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sician; The sertificate irector, pag	Be C	25. Was case referred to medica examiner?					26. Place o	of Death (C	Check only o		1 ☐ Yes	26 NO
S 0 =	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	ient 2 ☐ ER	/Outpatient	3 DOA Oth					☐Other (Specify	()
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al or Attending s after death. It Director: After	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ined 28e. Place of in	jury - At home tc. <i>(Specify)</i>	, farm, stre	et, factory, office		28f.	Location (S City or Tow	treet and I n, State)	Number or Rura	Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifyii (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis and manner s	of examination	dge, death and/or inv	occurred at the ti estigation, in my	me, date and opinion, death	place, and occurred	d due to the d at the time, d	cause(s) ar	nd manner as st lace, and due to	ated. the cause(s)
To th within To th	Me	29b. Signature and title of certifie				29c. Licens	e number		2	29d. Date s	signed (Month, L	Day, Year)
		Mal a	Val			DETCT						ŕ
5		30. Name and address of person	who completed cause of	death (Item 22	la) (Tune =	D51616				2/2	5/2007	<u>.</u>
		Nelson Kalil, M.D				#130, Che	Oh	MT	2007.5			
St	ate	31. Date filed (Month, Day, Year)	32. egist	rar's Signature	avenue	#130, Une	vy unase	<u>'_(للالــو:</u>	ZUB L 5			
Regist	rar	MAR 0 1	2007	m. K		and o						

		For	State of Ma	ryland /				Mental Hy	/giene	007	00000
		State Registrar		<u> </u>	Cer	tificate of	Death		Reg. No. C	UU/	00223
Physicia		1. Decedent's Name (First, Middle, La Anna Eli		olan				2. Date of De Month Febru	Day	3 200	3. Time of Death 7 6:10 AM
/Medica		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	or Location of Death			nty of Death	
	3	CIVISTA MEDICA				LAPLA			CHA	RLES	
Funeral Director		031-14-58/6	Sex 7. Age I□M 2 X F	(In yrs. last I	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, D	ay, Year)	Coul	place (State or Foreign ntry) MA
pus .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lor	ation					10d. Inside City Limits
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th the or 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cou	ntry?
ath wi	ra	1306 Leicester					20646			SA	
er deg	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	as Decedent of F Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	0- 14. R	Race - Americ Black, White,	
33 Same	þ	1 ☐ Never Married ② Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	0	1	□Yes 2□XNo	Specify:		Spe	cify: W	hite
5-0 72 hc	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16	a. Deced	ent's Usual Occup	oation during most of worl d)	kina	16b. Kind of	Business/In	ndustry
within sine.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)				3			
d 2 filled Phygie other ant, th		17. Father's Name (First, Middle, Last)		<u> </u>	feteria	18. Mother's Nam	ne (First, Middle			chools
lah lah Jid be Mental Mental Ked d	o Be	John Roche					Mar	y Roche		,	
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e, Co.		Mary Boley/Daugh	ter	Jook Blass	1306	Leiceste	er Drive,	La Plat	a,MD 2	0646	
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	ceme	tery, crem	atory or other pla	ce)	Date	20c. Location	•	
Baltimo permit. Page Department of Important: If any Injury or	Ì	4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lices		Kesui 100945			etery 3/2		Clinto		yland
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est .		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	the death. Do	not ente	r the mode of dyir	ng, such as cardiac	or respiratory a	aca, PiD irrest,	2064	Approximate Interval Between
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68760, ifficate be exe g physician a st the burial-	edical		d								
Box 6 leath certificate attending for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p						23d. [Date of delive	erv
e death	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2 4□Pregnant at t 9□Unknown			Ectopic pregnancy Other (specify) _	y 			Month	Day Year
P.O. hat the de d by the detached	P S	9 ☐ Unknown Part II. Other significant conditions		not resulting	in the un	Harlisha sauca siy	en in Dod I	One Did	lahaas us s		the server of death 0
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Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and it in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by	Pepiessiun Chronic Kid Diabetes m	ellitus	HYD	oth	y roid	um.	auto		prior to condeath? 1 ☐ Yes	mpletion of cause of
Vital Residan: The la	D Pe	25. Was case referred to medical examiner?					26. Place of Deat	th (Check only o	one)		
Or \Physic this co this co all direction	0	1 ☐ Yes 2 No	Hospital: 1 Inpatien	t 2 ER/C			er: 4 Nursing Ho	ome 5 ☐ Resi	dence 6 🗆 C	ther (Specif	(y)
On On Ging Figures:	Certification:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b	. Time of Injury	28c. Injur Wor	ryat k? Yes 2 □ No	28d. Describe	how injury occ	urred	
Visic Attend r death ector:	ilca ilca	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, i	farm, stre			28f. Location (Street and Nur	nber or Rura	al Route Number,
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Divisic To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Ph	y sician: To the best of niner: On the basis of e and manner state	examination a	ge, death and/or inv	occurred at the tire estigation, in my c	me, date and place, opinion, death occur	and due to the rred at the time,	cause(s) and date and place	manner as s e, and due to	stated. o the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	,			29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)
		Kom	deun			D- 6	51614		Febru	ary o	28,2007
9		30. Name and address of person who	•			,				<u> </u>	
State		RAVINDER K. SI 31. Date filed (Month, Day, Year)	NDHWANI 1 32. Redistrar	1350 's Signature	PEM	BROOK S	SQ. SUIT	E 304	WALDO	RF, M	ID 20603
Registra	_	MAR 0 2	32. Pigistrar 2007	w K	do	suff.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:47 A M Frances Kelemen Palenscar February 26, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ■ M 2 🖫 F Yrs. 101-12-6871 86 2, 1920 New York **Director** Nov. Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 700 Americana Drive, Apt. 22 21403 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic mans. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Kelemen Frieda Kravits 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21401 19a. Informant's Name/Relationship (Type. Print) Alexander J. Palenscar, Jr./spouse 700 Americana Drive, Apt. 22 Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Wall 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cemetery 3/15/2007 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ortic Stenosis **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an hast autopsy performed? res 2 certificate 1∐ Yes l or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P this within 24 hours after deau..

To the Funeral Director: After the committee of filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D61829 2001 Medical Parkway 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reynaldo Lee - 6/acer Annapolis, MD 31. Date filed (Month, Day, Year) . Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			For State	State of Maryland /				Mental Hy	giene	17 08225
			Registrar		Cer	tificate or	Death	2. Date of De	Reg. Nó.	3. Time of Death
*	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) REGINALD LEE	PRATT, SR.	•			FEBRUAR	Y 14, 2	2007 1940 P ^M
	Examin	41	4a. Facility Name (If not institution, give sti PRINCE GEORGE'S HOS			· ·	, or Location of Dea HEVERLY	th	4c. County of	of Death E GEORGE 'S
7 × 3	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Day		8. Date of Bir (Month, Da	1,1941	9. Birthplace (State or Foreign Country). Virginia
	Director	⊢	Usual Residence of Decedent	0.5				Dec. 1	.1,1541	
	Aanylan Febow		Md. Prince Go	10c. City, To		cation Fort Was	hington			10d. Inside City Limits 17☑ Yes 2 ☐ No
	th the h or 28e-)lrect	10e. Street and Number	orge 5	_	10f. Zip Code	,		10g. Citizen of W	
	23a	la l	1624 Taylor Aven			1	20744			ed States - American Indian,
' 0	be filed within 72 hours after death with the Maryland at Hygiene. A tell Hygiene death with the "healtral", or items 23a or 28e-f ehow dother then "healtral Examinar must be notified at event, the Modical Examinar must be notified at	표	11. Marital Status 1 Never Married 2X Marned	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No			f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Black	k, White, etc.
0036	hours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔯 N dent's Usual Occ			Specify:	Brack
215-	hin 72 9. 9n "net	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give lite.	kind of work dor DO NOT use reti	ne during most of wo ired)			
21	filed wit Hygien ther th	Con	12th		Co	onstruct	ion Worke			nstruction
Maryland 21215-0036	buid be filed Mental Hygi arked other atic event, II	To Be	17. Father's Name (First, Middle, Last) William A. Pr	att			18. Mother's Na	Ruth Ho	, Maiden Sumami Lmes	θ)
Mary	and le m		19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address <i>(Stre</i>	et and Number or F	Rural Route Numb		State, Zip Code) 737
	1 and Health em 27 ther tr		Gloria Pratt / D 20a. Method of Disposition	3		osition (Name of matory or other p		Date		City or Town, State
nor	ages ant of it: If It y or o		1 ☐ Burial 2 X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Ches	etery, crei :apeal	matory or other p ke Crema	atory 2-22	2-07	Belt:	sville, Md.
Baltimore,	permit. Pages Depertment of the Important: If Ite any injury or of		21. Signmun of Funeral Service of enser	1 1.11	1 22	2. Name and Add	dress of Facility (Capitol M	Mortuary	, Inc. ton. DC 20002
20	402 6 4		23a. Part1. Enter the disease or gomplio	ations that caused the death.	Doy of ent	$425~\mathrm{Mam}$	rland Ave	. , IN . E . ac or respiratory a	wasning arrest,	Approximate Interval Between
	Physician		shock, or heart failure. Ust dnly one tmmediate Cause (Final disease or condition resulting in death)	cause on each life.	BIN	10 91	RRHYTH	MIA		Onset and Death
	/Medical Examiner			Due to (or as a consequen	nce of):					
	pe isi	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	nce of):					
oʻ	ate be executed hysicien end he burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequen	nce of):					
68760,	cate be physicia the bu	dicai	d.							
Box 6	eath certificat attending phy I for use as the	n/Me	23b. Was decedent pregnant	c. If yes, outcome of pregnancy		⊒Ectopic pregna	incv			te of delivery
.O. B	The law requires that the death certifical ate hes been signed by the attending phypage 2 should be delached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown		Other (specify			Moi	nui Day real
α.	es that tigned by	by Ph	Part II. Other significant conditions conf	ributing to death but not resulting	ng in the u	underlying cause	given in Part I.			ribute to the cause of death?
Records,	w require been sig should b	eted			-			24a. Wa:	s an 24b. \	Were autopsy findings available
Rec	The lav	Completed						auto perf 1 ☐ Yes	opsy ormegi?	prior to completion of cause of death? I ☐ Yes 2 ☐ No
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					eath (Check only	one)	
of V	Physicien: this certific ral director,	ို	1 ☐ Yes 2 No			111 3 DON			how injury occur	
ion (Attending F is death. ector: After by the funera	ation:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury 28 (Month, Day Year)	8b. Time o Injury		njury at Work? I □ Yes 2 □ No	200. Describe	riow injury occur	
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, st	treet, factory, offi	се		(Street and Numb own, State)	per or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Co	(Check only 2 Medical Examin	icians to the best of my knowle er: On the basis of examination	edge, Jeili n and/or ir	th conuitad at the	s time, data and ula ny opinion, death oc	ce, and due to the curred at the time	e cause(s) and ma	anner as stated and due to the cause(s)
	in 24	Medi	29b. Signature and the of certifier	and manner stated.						
	o 들 o 는	_				29c. Lic	aliza ilgilibai	/		d (Month, Day, Year)
	Vith To To Com	T		xtt)		29c. Lic	5895'	1		
Űί	To To To To To To To To To To To To To T		30. Name and address of verson who co		3a) (Type	1	5895' Dx	CHEVEN		d (Month, Day, Year) 16-07 1D 20185

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 200^{Year} EUGENE DELMORE PRATT 21, FEB. /Medical 8:20 PM 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5413 Bishops Head Court Columbia HOWARD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 M 2 □ F 215-12-4152 Director 84 Apr. 21, 1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" ~ ... any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5413 Bishops Head Court 21044 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 □ No
If Yes, Give
Year or Dates: 44-45 1 ☐ Never Married 2 ☐ Married þ 1 ☐ Yes 2 ☐ No Specify: Widowed 4 ☐ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth Maintenance Worker City of Rockville 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Russell Nugent ٥ Elsie Hackett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Claggett (Daughter) 5413 Bishops Head C., Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burian 2X Cremation 3 ☐ Removal from State 🎢 erdale Park Cre. 2/27/07 4 □ Do and on 5 ☐ Other (Specify) Riverdale, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. of Funeral Service Licer 246 N. Washington St, Rockville, MD 20850 e, or complications that caused the death. List only are cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Prostate Cancer Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause English and the Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death Month Year signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Anemia Completed 1 Tes No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes No No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56797 2/27/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lautha Tadikonda, M.D. 13952 Baltimore Ave., Laurel, MD 20707 31. Date filed (Month, Day, Year) FEB 2 8 2007 State Registrar's Signature Registrar

07-01750 Dolores Quander

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1-For State Criticate of Maryland / Department of Registrar			eg. No.	UULL
Physici				2. Date of Death Month March 5, 2	h	3. Time of Death 1715 hrs
ilcar Exam	IIIGI	borores n. Quantier	4b. City, Town, or Location of Deat		4c. County of Death	
		Sinai Hospital	Baltimore		, , , , ,	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Mi	_	h(MM/DD/YYYY) 9. 8irt Foreig	n
Director		577-46-0506 1 M 2XF 79 Yrs		Oct. 3	, 1927 Co.	^{untry} Washington
any		10a. State 10b. County 10c. City, Town or Locati	on			10d. Inside City Limits
	o	DC N/A Washingto	on			1 X Yes 2 No
Maryl r 28a-1	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	itry?
eath with the Maryland items 23a or 28a-f sho ust be notified at once.			20002 s Decedent of Hispanic Origin? (§	Inneify Voc or No	U.S.A.	non Indian Plack
leath w	Funeral	1 Never Married 2 Married 1 Yes 2 X No	es, specify Cuban, Mexican, Puert		White, etc.	can indian, black,
after d al", or	by Fi	3 X Widowed 4 Divorced If Yes, Give Year 1 or Dates:	Yes 2 X No specify:		Specify: Bla	ck
hours 'natur Exam			t's Usual Occupation (Give kind of ost of working life. DO NOT use re		16b. Kind of 8usiness/li	ndustry
336 thin 72 than than dical	Completed	2 Recei	otionist		BCBS	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, th. M. diea				e (First, Middle, M		
2121 ould be fi Mental marked	o Be		Doroth Address (Street and Number or	ny M. Kit		7:- 0-4-)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, th. M. disal Examiner must be notified at once	ř					
re, N 1 and 1 Health Fitem		20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other states or the state of Disposition crematory or other states or other states or other states or other states or other states or other states or other states or other states or other states or other states or other states or other states or other states or	7th St. N.E. Was	Date	20c. Location - City or	Town, State
Baltimore, permit Pages I ar Department of Her Important: If ite		1 Z Duria 2 Gremation 3 Removalitori State	ny Cemetery Man	ch13, 2	007 Landove:	r, MD
Salt ermit Departu mport njury						
Physician		23a. Part I. Enter the disease, or complications hat caused the death. Do not enter the	OO Georgia Ave., ne mode of dying, such as cardiac	N.W. Wa or respiratory arre	st, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Fat emboli complicating limes)	nvoertensive athero	elerotic c	rardiovascular	8etween Onset and Death
		or condition resulting in death) Due to (or as a consequence of): diseas	2			
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Box 687 c death certific the attending p	sician/	past 12 months? 4 Pregrant at time of death 5 Ott	ner (Specify)			•
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ords, P.O. It requires that the as been signed by a should be detach	2			1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should the	Completed	to the second se		24a. Was a		opsy findings available ompletion of cause of
tal Reco	omp			perform 1 ✓ Yes 2	med? death?	
Vital Rec ysiciau: The his certificate director, page	BeC	25. Was case referred to medical	26.Place of Death (Check			
of Vid Physic er this eral dire	ျ	1 V Yes 2 No Inpatient 2 ER/Outpatient 2 ER/Outpatient 2 No Inpatient 2 ER/Outpatient 2 No Inpatient 2 ER/Outpatient 2 No Inpatient 2 No Inpa			Residence 6 Other	
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Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	4 Homicide determined (Specify)		or rown, st	ale)	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.						
To t To t	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	
		Culine of Ac	O.C.M.E.		March 6, 2007	
		30. Name and address of person who completed cause of death (Item 23a)	Observe Delivers 145 A	1004		
			n Street, Baltimore, MD 2	1201		
Si Regis	tate	MEAN DE 1 C. / 1111 / 1898 - 48 / 2008	All s			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February 27, 2007 Robert William 7:39 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7439 First League Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1**y** M 2□ F 577-32-1039 22, 1928 Virginia Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 14512 Fiske Drive 20906 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces:
1 □ Yes 2 □ No
If Yes, Give Korean
Year or Dates: Conflict 1 ☐ Never Married 3 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Moving & Storage Company

Physician /Medic Examine

Physician

/Medical

Director

Funeral

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Examiner

Funeral

Director

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

requires that the death certificate be executed attending p Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:

completely filled in by the

Division or Vital Records, P.O. Box 68760

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	To Be Completed by Physician/Medical Examiner
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	Certification: To
	Medical

-		Conf	LICT								
Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Decedent's Usual Occu	during most of working	16b. I	16b. Kind of Business/Industry					
Ē	Elementary/Secondary (0-12)	College (1-4or 5+)	0	,	L.		~				
ၓ	17. Father's Name (First, Middle, Last,	1	<u>Owner</u>	18. Mother's Name (Fi			orage Compa				
Be			_	rst, ivilouie, ivialoe	n Surname)						
ပ္	Herman Wadsworth	Longfellow Ro		Rosalie El:							
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Stree	t and Number or Rural Ro	oute Number, City	or Town, State, Z	?ip Code)				
	Terri Hopkins Ro	hr/ Wife	14512 Fiske	Drive, Silve	er Sprin	g, MD 20	906				
	20a. Method of Disposition	20b. F	Place of Disposition (Name of cemetery, crematory or other pla	Date		ocation - City or	Town, State				
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inemoval nom State		1 100.	28						
	21. Signature of Funeral Service Licer	. Ine	tropolitan Cre	matory 200 ess of Facility Collins Fu		exandria.	, Virginia				
	Da. Ka. Svla										
	23a Part Enter the disease or com	unlications that caused the deal		rsity Blvd,		er Spri	Approximate				
	23a. Part. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	in. Do not enter the mode of dy	ing, such as cardiac or re	spiratory arrest,		Interval Between Onset and Death				
	Immediate Cause (Final disease or condition	Cerebrovasc	ular Accident				48 Hour				
	resulting in death)	Due to (or as a conseq									
	Sequentially list conditions	Diabetes Me	llitus				17 year				
ner	Sequentially list conditions,	Due to or as a conse	uence of):								
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
Due to [or as a consequence of]: Cause (Disease or injury that initiated events resulting in death) Last FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1											
cal	d										
edi		F V.									
Š	IF FEMALE: 23b. Was decedent pregnant	23d. Date of deli	van								
ciar	in the past 12 months?		Month	Day Year							
ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown										
문	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the										
ð.	Hyperlipidemia, Hypertension 1√2 Yes 2□No 3□Prol										
stec	Hyperlipidemia, Hypertension										
ğ					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of				
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e C	25. Was case referred to medical			26. Place of Death Cl		0 1 1 1 1 1 1 1 1					
OE	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA Ot	hor:		6▼ Other (Sne	oifyDaughter's				
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ertii	4 ☐ Homicide determined	building, etc. (Specif	ý)		City or Town, Star	e)	nar rioute rumber,				
Ŏ	29a, Certifier 1 Certifying Ph	veician: To the hest of my kno	wledge, death occurred at the t	imo dato and place, and	due to the course	a) and manage	-4-4-4				
	(Check only 2 Medical Exam	niner: On the basis of examina	ation and/or investigation, in my	opinion, death occurred a	at the time, date a	nd place, and due	to the cause(s)				
Med	0.10,	and manner stated.		se number							
	29b. Signature and title of certifier	, 1	1 -	se number		ate signed (Month					
	David K	dance, mi	U. V.	21133	0	2/28/	07				
	30. Name and address of person who										
	Barry K. Lance, I	M.D. 14201 Lat	urel Park Drive	e, #214, Lau	rel, MD	20707					
te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature								
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			1 - State of Ma		artment of H rtificate of		nd Mental Hy	giene Reg. No. 200	7 08229
Vii.	Physici /Medic		1. Decedent's Name (First, Middle, Last) Helen Cook		Richards	on	2. Date of De Month	ath	3. Time of Death 3:47 P
	Examir		4a. Facility Name (If not institution, give street and number) 3160 Gracefield Rd-Riderwood	d Village	4b. City, Town, c		Death	4c. County of Montgo	Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of Bir (Month, Date 08-26-	ıy, Year)	B. Birthplace (State or Foreign Country) Iaryland
	show ad at	or.	Usual Residence of Decedent	10c. City, Town or Lo					10d. Inside City Limits 1 [XYes 2 □ No
	th the M or 28a-f e notifie	Director	10e. Street and Number	DIIVEL DP	10f. Zip Code			10g. Citizen of Wh	
2000-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleem 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral I	3160 Gracefield Rd. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 22 N (ref Yes, Give Year or Dates:	0	2090 Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2☐ No		in? (Specify Yes or No Puerto Rican, etc.)	US 14. Race - Black, Specify:	A American Indian, White, etc. White
0-61213	I within 72 ho jiene. r than "natui the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	-) (Give	dent's Usual Occup kind of work done DO NOT use retired	during most (d)	of working	16b. Kind of Busin	•
מומ	ld be filec ental Hyg ked othe ic event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Raymond Fraise Cook		211000 OW	18. Mother	s Name <i>(First, Middle</i> rma Amelia	Maiden Surname)	
Maly	id 2 shou Ith and M Ith and M 27 is mar traumati	-	19a. Informant's Name/Relationship (Type. Print) Margaret Machado-Poisson			and Number	or Rural Route Numb everna Par	er, City or Town, St	
ָנֻ ס	ages 1 ar ent of Hea it: If item 2 y or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ce)	Date 3-05-2007	20c. Location - Ci	
חשונון	permit. P Departme Importan any injur once.		21. Signature of Funerial Service Livensee		2. Name and Addre	ss of Facility	Joseph Gav Ave. NW Was	wler's So	ns Inc.
	Physician		23a. Part1. Enter the disease, or complicity in sithat caused shock, or heart failure. List only on a cause on each line immediate Cause (final disease or condition Conge.		ter the mode of dyi	ng, such as c			Approximate Interval Between Onset and Death Vears
	/Medical Examiner		resulting in death) Due to (or as a	consequence of):					years
,00,0	cate be executed hysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):					_
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome r 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	□Ectopic pregnanc	/		23d. Date of Month	*
, ,	quires that n signed by	by	Part II. Other significant conditions contributing to death but Arterial Fibrillation	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	37	ute to the cause of death?
	The law rerate has bee page 2 shor	Completed					24a. Was auto perfo	osy prio ormed? dea	ere autopsy findings available or to completion of cause of ath?] Yes 2 □ No
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending (Month, Day) 27. Accident investigation	/ 28b. Time o	f 28c. Injui	er: 4□ Nurs	of Death Check onl of Sing Home 5 Resi	one A c	
	ial or Atten s after deati al Director: ed in by the	Certification:	Z D Acoldelli	y - At home, farm, str (Specify)		100 2		Street and Number vn, State)	or Rural Route Number,
	ne Hospi n 24 hour ne Funeral	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or in	h occurred at the ti vestigation, in my	me, date and opinion, deati	I place, and due to the h occurred at the time,	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
(1		Me	29b. Signature and title of certifier	1	29c. Licens	e number		29d. Date signed (
10			30. Name and address of person who completed cause of de 3110 Gracefield Rd. Silve		Print)		ried		
	Sta Registr			to Ottom where	will .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Oldio (or wary lar	Cei	tificate of l		Re	eg. No.	00/	08230	
	Physici	ian	1. Decedent's Name (First, Midd	e, Last)					2. Date of Deat	h Day	Year	3. Time of Death	
4.7	/Media	cal	Mary Helen 4a. Facility Name (If not institution				4h City Town or	Location of Doot	March		200 County of Deat		
	Examir	ner	Washington Cou		,			4b. City, Town, or Location of Death Hagerstown			Washington		
	Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		If Under 24 Hrs. Hours Min.			9. Birt	hplace (State or Foreign untry)	
ы	Director		220-28-3065	1□M 2 X 1F	91	Yrs.	WOTHIS Days	Tiodis Will.	Sept. 8			nsylvania	
land	t ow		Usual Residence of Decedent 10a. State 10b. County	r	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
Many	ified a	į	Marvland Wash	ington		Наое	rstown					1∭∑Yes 2 □ No	
th the	or 28a e noti	Directo	10e. Street and Number	Ing con		mage	10f. Zip Code		10	0g. Citize	en of What Co	untry?	
ath wi	23a ust b		815 Maryland A					740			USA		
ter de	items ner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed F	cedent Ever in U orces?	.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14	4. Race - Ame Black, White		
036 urs af	ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, G Year or I	2 X No live Dates:		1∐ Yes 2 X No	Specify:		5	Specify:	White	
215-0036 Ithin 72 hours af	natur Jical B	Completed	15. Deceder	nt's Education est grade completed,)		fent's Usual Occup		rkina I	16b. Kind	d of Business/	-	
Ithin	han " e Med	d d	Elementary/Secondary (0-12)	College	(1-4or 5+)	life, L	DO NOT use retired	i)	ng		_		
d 2	Hygie ther t	ပ္သိ	8 17. Father's Name (<i>First, Middle</i>	Last)		Home	emaker	18. Mother's Nar	me (First, Middle, M		<u>own</u> he	ome	
d be	fental rked o tic eve	To Be	Charles Henry	Mullenix				Feta M	lae Vinso	n	,		
laryla 2 should	is mar	-	19a. Informant's Name/Relations			19b. Mailin	g Address (Street		ural Route Number		Town, State, 2	Zip Code)	
Saltimore, Maryland 21 permit. Pages 1 and 2 should be filed w			Elenora Murray	– Daught		46	S. Coloni	al Drive	, Hagers				
more Pages 1			20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐Removal from	ı State	cemetery, crer	sition (Name of natory or other plac	i i		20c. Loca	ation - City or	Town, State	
Itim F: Pa			4 ☐ Donation 5 ☐ Other (3		Ro	se Hil	1 Cemeter	y 3/6/	07 1	Hage	rstown	,_Maryland	
Balt	Impo any i		SCOXI	ma	Junes				linnich F			e land 21740	
8			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that	caused the deat						, mary	Approximate Interval Between	
Ph	nysician		Immediate Cause (Final disease or condition	-	ATERAL	Moi	TILOBAR	PALEU	MONIA			Onset and Death	
	Medical xaminer		resulting in death)		(or as a conseq	uence of):		- // - /	101017			10 0/1/3	
	kanimer «	<u></u>	Sequentially list conditions,	b. — Due to	(or as a conseq	mence of):							
nted	Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ 500.0	(or as a conseq	denoc oi).							
U, exect	in and	Еха	that initiated events resulting in death) Last	C. Due to	(or as a conseq	uence of):							
C 58 / 50, rtificate be executed	physician and is the burial-transit	Medical		d									
	5, 6		IF FEMALE:	220 If you o	utcome pf pregna	anav							
BO O	attendir for use	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 ☐ Feta nant at time of d	al death 3□	Ectopic pregnancy Other <i>(specify)</i>	,		23	Bd. Date of del Month	ivery Day Year	
HECOLDS, P.O. BOX The law requires that the death ce	been signed by the should be detached	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkr									
S, T	gned be	by P	Part II. Other significant condition			_				acco use	e contribute to	the cause of death?	
	een si	ted	HYPERTENSI	on : A	THEROS	CLERO	TIC CA	RDIOVASO	CU- 1 = Ye	s 2	rNo 3⊟Pr	obably 4 Unknown	
e law r	nas be e 2 sh	Completed	LAR DISTAS	E, REN	AL IN	SUFF	CIENCY		24a. Was ar autops	n y	24b. Were au	topsy findings available completion of cause of	
									perform 1∐ Yes 2	ned? No	death? 1 ☐ Yes	2 □ No	
VIT	s certif irecto	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2□	ER/Outpatien	t 3 DOA Othe		ath (Check only on		□ (2)	· ·	
g Phy	er this eral d	n: To	27. Manner of Death	28a. Date		28b. Time of Injury			lome 5 Reside			oify)	
si Or	ath. or: Aff he fur	atio	1 Natural 5 Pendii 2 Accident investi	gation	nin, Day Tear)	пдагу		Yes 2 □ No					
UIVISION I or Attending	fter de Xirect In by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined Zoe. Plac	e of injury - At ho ling, etc. (Specif	ome, farm, stre	eet, factory, office	-	28f. Location (Sti City or Town	reet and , State)	Number or Ru	ıral Route Number,	
pital	eral C		29a. Certifier 1 Certifyi	ng Physician: To th	e hest of my kno	wledge death	occurred at the tin	ne date and place	and due to the co	21150(E) 0	and manner of	atatad	
e Hos	within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, s	edical	(Check only 2 Medical one)	Examiner: On the I	basis of examina nner stated.	ation and/or in	vestigation, in my o	pinion, death occi	urred at the time, d	ate and p	place, and due	to the cause(s)	
To th	withir To th comp	M	29b. Signature and title of certific	ir /	1 1		29c. License	e number	29	9d. Date	signed (Monti	h, Day, Year)	
			Vand to	4 Brod	pol		738	892		31	2/20	07	
5H-	115		30. Name and address of person	who completed c	se of death (Item	n 23a) (Type,	Print) SUIT	E 130	0 4410	11	HAR	SERTANN,	
J113	Sta	ate_	31. Date filed (Month, Day, Year,		Registrar's Signa	ature J	. 11110/1	WIGH	CATPU!	NJ	[1]	21742	
	Registr	-	MAR 0	5 2007	Seen .	B. A.	oute		/				
DHMH	17 Rev 1/2	001				1							

			For State Registrar	State of Man		rtment of F tificate of t	lealth and Me <i>Death</i>	ntal Hygie Reg.	pro pro con prog	0.0231
п			Decedent's Name (First, Middle, Last)				2	2. Date of Death		3. Time of Death
	Physicia		Gwendolyn Ann	Robey			Fe	Month ebruary	28,2007	11:25A M
947.	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death	Julian	4c. County of Death	110001
			Waldorf Center			Waldo			Char1	es
	Funeral		Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign ntry)
В	Director		220-74-9819	M 2X F	71 Yrs.			igust 16		shingtonDC
	and w		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	daryta f sho led al	ō	MD Charles	3	Waldorf					1 ☐ Yes 21 No
	the 28a-	rec	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What Cou	ntry?
	3a or		12303 Burning Oak	Court		206	501		USA	
	death ms 2 r mus	Funeral Director		Was Decedent Ever Armed Forces?	er in U.S. 13. \		lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ameri Black, White	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifled at once.	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	I ☐ Yes 2☐XNo	Specify:	oan, oto.,		hite
2	72 ho natur lical l	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	lent's Usual Occup	oation during most of working	16	b. Kind of Business/Ir	idustry
2	ithin ithin an "	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of working d)			
7	led w lygier her th	S	7 17. Father's Name (First, Middle, Last)]	<u>Disabled</u>	18. Mother's Name (First Middle Mai	idan Surnama)	
and	be fill he fill he ever	To Be	Joseph Willard Rol	NOTE ST			Annie L.		iden Surname)	
Ž	hould Id Me mark matic	卢	19a, Informant's Name/Relationship (Typ		19b. Mailir	a Address (Street	and Number or Rural		ity or Town, State, Zi	n Code)
Z	nd 2 s Ith an 27 is		Joanne Kellam/Siste		l l	-	shway 58 Sc			·
ē,	s 1 ar f Hea item 2		20a. Method of Disposition		20b. Place of Dispo cemetery, cren	sition (Name of	Dat	te 200	c. Location - City or T	own, State
altimore,	Page ent o nt: If ry or		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emovai irom State I			ery 3/2/2	2007 Po	omfret,Mar	vland
a E	permit. Departm Importal any Inju		21. Signature of Funeral Service License		-		ess of Facility ECHOLS FUNE			
m	a III		South (L	chile			fary's Ave.			46
E			23a. Part1. Enter the disease, or complice shock, or hear failure. List only on	cations that caused the cause on each in .	e death. Do not ent	er the mode of dyir	ng, such as cardiac or	respiratory arrest	·	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	alhe	roscly	stic Ca	dovascul	in des	lase	Onset and Death
Fig.	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):	,				
1	Examiner	_	Sequentially list conditions, if any, leading to immediate	Due to (or as arc	pertinsis	~				
	ped lisit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as and	prisequence or).					
In.	icate be executed physician and s the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a c	onsequence of):					
68760,	siciar buris	dical								
189										
ŏ	h cert ending use a	M/III	23b. was decedent pregnant	3c. If yes, outcome pf 1 ☐ Live birth 2 l		Ectopic pregnanc	.,		23d. Date of deliv	*
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tin		Other (specify)	у		Month	Day Year
Records, P.O. Box	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/M	9□Unknown					T		
<u>ග</u>	res th igned be de	by f	Part II. Other significant conditions con	tributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to 2 No 3 □ Pro	
oro	w requir been si should	Completed						T Tes	2 2 NO 3 PIC	bably 4 □Unknown
ec Sec	e 2 sh	nple						24a. Was an autopsy	prior to or	opsy findings available ompletion of cause of
ᇤ	: The	Sol						performe 1□ Yes 2□	d? death? 1 ☐ Yes	2□No
Ĭ	sician certifi rector	Be	25. Was case referred to medical examiner?	ospital:		t all DOA Oth	26. Place of Death (
ō	Phys r this ral dii	. To	1 ☐ Yes 2 📉 No ☐	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien	I SUDOA	4/1 Nursing Home	e 5 ☐ Residend 3d. Describe how	e 6 □Other (Specinium occurred	ify)
Division or Vital	Attending r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y		Wor	rk? Yes 2∐No		mjery ecounted	
S	Atten deat sctor	fica	3 ☐ Suicide 6 ☐ Could not be		- At home, farm, str	eet, factory, office	28		et and Number or Rui	al Route Number,
5	al or s after	Certification:	4 ☐ Homicide determined	building, etc. (<i>Specify)</i>			City or Town, S	state)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (camination and/or in		me, date and place, ar opinion, death occurred			
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	1/-		29c. Licens	se number	29d	. Date signed (Month	, Day, Year)
			► \\	Un		1) 2	2574	Mo M	íarch 1,	2007
)		30 Name and address of person who co		A A	Print)			00 A 30	v oil
	DBI		Robert Page M	D 120		ne Ctr =	#302 W	aldurt.	MIN) ZC	4001
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 2 2	32. Registrar's	Signature	land.				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0000 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** HILDA MELVINA 2007 17, 2007 4c. County of Death 1815 /Medical February 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany S Birthplace (State or Foreign Country) Maryland Cumberland
If Under 1 Year | If Under 24 Hrs. Memorial

5. Social Security Number 8. Date of Birth (Month, Day, Year) 03/09/1920 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 ☐ M 2 🛱 F 86 Director 220-10-9398 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notifled at 1 ☐ Yes 2 X No MD Allegany Cumberland Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 21502 11900 Knob Road by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify. Specify. 3 ☑ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within leath and Mental Hygiene.
n 27 is marked other than "n. er traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be R. Smith Laura Α. Crites James Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. 10404 M.V. Smith Road, Flintstone, MD James W. Root 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee MD Vet. Cem @ Rocky Gap 02/21/2007 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD rate 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. thath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for Month Year in the past 12 months? Day 5 Other (specify) signed by the at a be detached for 1 □ Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Renal failure Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ∐ Yes 2 No 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 18 2007 D36766

State Registrar

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Dr. Vik Poonai,

FEB 2 0 2007

31. Date filed (Month, Day, Year)

Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

924 Seton Drive,

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760,

		1 - State Registrar					Cer	tificate of	Death	7		Reg. No	20	0.7	na	2233
Dhusisi		1. Decedent's Name (First, Middle	e, Last)								2. Date of Month	Death Da	v	Year	3. Time	of Death
Physici: /Medic		Lillie	Jane	e Ray	у						Febru	ary,	28 2	007	1:25	P M
Examin	er	4a. Facility Name (If not institution	n, give str	eet and nu	mber)			4b. City, Town, o		of Death	1	4c.	-	of Death		
		Beverly Healt		re	7 //	to - 4 fe/	tust alou N	Frederi		er 24 Hrs.	O Data of	Diath	Fr	eder		- Court
Funeral		5. Social Security Number	6. Sex 1 □ I	v 2 K□ F	7. Age (1.	n yrs. last bi	Yrs.	Months Days	Hours			Day, Year)		Cou	place <i>(Stat</i> e ntry)	or Foreign
Director		213-16-1002 Usual Residence of Decedent				88	1.4				March	4, I	918	Mary	Land	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08234 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 26, 2007 **Physician** Eunice Kathleen Rhoderick 5:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carrol1 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Yrs. Director 216-22-9966 3, Virginia Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or Itama 23a or 28a-f show other rest by notified at 1 ☐ Yes 2 X No Directo Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic avent, the Medical Examinant barne once. 4101 Old National Pike 21771 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Lloyd Emswiler Martha May Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1089 Lost River Ridge Circle 19a. Informant's Name/Relationship (Type, Print) 1089 Lost River Ridge Circle Wardenville, West Virginia 26851 Karen Johnson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 3/2/07 Memorial Gardens 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Licensee 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrythmia minutes /Medical Due to (or as a consequence of): Examiner Atherosclerotic Heart Disease years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ceberal Vascular Accident, Diabetes Mellitus, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension and Dementia Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2X No 1□ Yes Hospitel or Attanding Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 3X DOA this ctor: After this 28b. Time of Injury 27 Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

To the

State Registrar

31. Date filed (Month, Day, Year) MAR 0 2 2007

29b. Signature and title of certifier

MW orders 32. Degistrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

010 9501

29d. Date signed (Month, Day, Year)

21046

			For State		State o	f Maryl	and / Dep	artmer <i>rtifica</i> :			and M	lental Hy	•	0 0 5	***3	00005
			Registrar 1. Decedent's Name (First	Middle, Last				itinca				2. Date of De	Reg. No.	606	+	3. Time of Death
*	Physici		Irving Sherl									FEB 2	26 Day	007 ^Y	ear	7:30 p M
5	/Medio Examir		4a. Facility Name (If not in	_		mber)				Location of	of Death		4c.	County of		-
			957 Mt Holl						poli:	S _ If Under:	24 Uro	0 D-1(D)		ne Ai		
-	Funeral Director		 Social Security Number 220–36–6935 	6. Sex	(]M 2□F	7. Age (In)	yrs. last birthday, 7 Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Dec 27	ay, Year)		Court Court	lace (State or Foreign and
	D		Usual Residence of Deced													
	arylan show d at	ž		_{Dounty} ne Arur	nde1		. City, Town or L .nnapoli								1	0d. Inside City Limits 1 □ Yes XXNo
	the M 28a-f notifie	Funeral Director	10e. Street and Number						p Code				10g. Citi	zen of Wha	at Cour	itry?
	3a or		957 Mt Holly	v Drive	2				1409					USA		•
	death ms 2 r mus	ners	11. Marital Status		12. Was Dec Armed Fo		n U.S. 13.	Was Dece	edent of H	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race -	Americ White,	
36	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2		1 X Yes If Yes, Gi Year or D	2□No L ve 1	959 - 965	1 ☐ Yes		Specify:	, , , , ,			Specify:		
21215-0036	hour tural	ed b		ecedent's Edu		ates: +	16a. Dece	dent's Us	ual Occup	ation			16b. Ki	nd of Busir	ness/Inc	dustry
215	hin 72 3. an "na Medic	Completed		/ highest grad			life.	DO NOT I	ise retired	•	t of worki	ing	Ī.,			
21	d with	E O	12				Parts	Depa	rtme					omot	Lve	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, I) Willard She									e (First, Middle owen	, Maiden	Surname)		
ary	shoul and M s marl umati	욘	19a. Informant's Name/Re	elationship (Ty	pe. Print)		I	_				al Route Numb	-			Code)
Ž,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau	1	Mary Jo She		Wife	100						apolis,				01-1
Baltimore,	ages 1 nt of H : If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem	nation 3 🗆 F	Removal from	State	b. Place of Disp cemetery, cre							cation - Ci	-	
ij	artmer artmer ortant injury	14	4 □ Donation 5 □ C		e	M	letro Cr		-			8 2007 desty 1				
Ba	Dem any any		170-	7.4	h-	•						apolis			-	2 1221
	***		23a. Part1. Enter the dise shock, or heart failu	ease, or convol	ications that ne cause on	caused the deach line.	death. Do not er	ter the mo	de of dyin	g, such as	cardiac	or respiratory a	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition		. We	T2AK	ANC	PA	NZF	FXF	(ANZE	12		8	Mount 2
	/Medical Examiner		resulting in death)		Due to	(or as a con	sequence of):									
	蒙世	Jer	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	s, te	o. Due to	(of as a con	sequence of).									
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		D	4										
8760,	be exe	al E	robaning in additity East.	- E	Due to	(or as a con	sequence of):									
687	ficate physis the	edical			d											
Вох	death certific attending p	M/u	IF FEMALE: 23b. Was decedent pregr	iani	23c. If yes, ou	tcome pf probints		□Ectopic _I	oregnancy	,			di:	23d. Date		,
-	The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as	Physician/Me	in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	s?		nant at time		Other (s						Month	1	Day Year
P.0	w requires that the de been signed by the should be detached		Part II. Other significant	conditions co	ntributing to o	leath but not	resulting in the	underlying	cause giv	en in Part I.		23e. Did	tobacco u	use contrib	ute to ti	ne cause of death?
Records,	luires n signe	d by	DIABLE	NES_	MER	UN	S					1 🗆	Yes 2	□ No 3	☐ Prob	pably 4 Unknown
000	s beer s beer	lete										24a. Was		24b. We	re auto	psy findings available mpletion of cause of
Re	hysician: The law his certificate has t I director, page 2 s	Completed										auto perf 1□ Yes	psy ormed? 2 XNo	dea	or to co ath?]Yes	mpletion of cause of
Vital	sian: ertifica ctor, g	Be C	25. Was case referred to examiner?							26. Place	of Deat	n (Check only	\rightarrow			
or V	> .∞ 0	은	1 ☐ Yes 25 No				2 ER/Outpatie			4 L NU		me 5 Res		6 □Other	` '	y)
ou 0	ding F	ion:		Pending investigation	28a. Date (Moi	of Injury oth, Day Yea	ar) 28b. Time Injury	M M	28c. Injur Wor 1 □	yat k? Yes 2⊡		28d. Describe	how injui	ry occurred	ı	
Division	Attending r death. ector: After by the fune	ifical	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Plac	e of injury -	At home, farm, s					28f. Location	(Street an	d Number	or Rura	al Route Number,
ă	ital or rs afte al Dir	Certification:	4 Pornicide		Duik	ling, etc. (Sp						City or To	own, State			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 2 0 N	ertifying Phy ledical Exami	iner: On the I	e best of my pasis of exar oner stated.	knowledge, dea mination and/or i	th occurre nvestigatio	d at the tir on, in my c	me, date ar opinion, dea	nd place, ath occur	and due to the red at the time	e cause(s e, date an) and manr d place, an	er as s d due t	tated. o the cause(s)
	To the within To the complete	Me	29b. Signature and title of	certified	- [] .	7		25	cicens	e number	1-1	1	29d. Da	te signed (Month/	Day, Year
			KOKEY	WW.	eu	1)			N	65	0	†	-	4	7	UI
11	0+1		30. Name and address of	person who b	orhpleted cau	se of death	(Item 23a) (Type	Frint)	ER	- Co	SUT	Any	UAF	ous	M	021401
	Sta Regist		31. Date filed (Month, Da		2007 32. 1	gistrar's S	Signature	4	2							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland	•	artment of I		nd Mental Hy	/giene)7 (082	36
0	Physici	an	Decedent's Name (First, Middle, Last) I A DAVID TO THE COMMITTEE TO					2. Date of D Month	Day	Year	3. Time of	M
>	/Medio		KATHERINE ELIZAS 4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of	FEBRUA Death	RY 23 2 4c. County		1:46	Р "
		٠	16923 VIRGINIA AVI				LLIAMS			ASHIN		
r	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last	Yrs.	Months Days	If Under 24 Hours	Min. (Month, D	ay, Year)		ce (State of y) YLAND	
	ס		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	agtion		DEO. 2	1)21		d. Inside Cit	
	Maryla fed at	tor	MARYLAND WASHING		01111 01 20		LLIAMS	о∩рт		100	1 🗆 Yes	
	th the	Jirec	10e. Street and Number	LOIN		10f. Zip Code	LILLAMO	OKI	10g. Citizen of V	Vhat Country	y?	
	eath w	Funeral Director	16923 VIRGINIA AVI	ENUE 12. Was Decedent Ever in U.S.	13 \	Was Decedent of	21795	n2 (Specify Ves or N		U.S.A e - American		
9	after d or Item mirer	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	f Yes, specify Cub 1 ☐ Yes 2 ☑ No		n? (Specify Yes or N Puerto Rican, etc.)		k, White, etc		
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-1 show fra Madical Exerciter must be mulified at	ed by	3 X Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:		dent's Usual Occu			Specify 16b. Kind of Bu	WHI		
215	hin 72 an "ne	Completed	(Specify only highest grade		(Give	kind of work done DO NOT use retire	during most of	of working	16b. Killd of bu	ISII I GSS/II I GU	istry	
	filed wit Hygiene other tha	Con	6 17. Father's Name (First, Middle, Last)		Н	OMEMAKER	10 Mathed	a Nama (Cirat Middle		HOME		
Maryland	should be fi nd Mental F marked ot umetic ever	To Be	ROY WILLIAM HIMES					s Name <i>(First, Middl</i> e E MAE HAWK		θ)		
lary	2 shou and M ie mar eumet	۲	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	ng Address (Stree		or Rural Route Numb		State, Zip C	Code)	
	요두다=		BRIAN D. STINE/GRA			3 VIRGIN sition (Name of	IA AVEI	NUE, WILLI	AMSPORT,			21795
E O	Pages nent of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Dopation 5 ☐ Other (Specify)	emoval from State	etery, cren	natory or other pla		2/28/2007		•		ANT
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Financial Service Licente		22	. Name and Addr AST FUNE	ess of Facility	7606 0	ld Natio			AND
	<u>~</u> □ = = =		23a. Part1. Enter the disease, or complic					Boonsb	oro, Mar		217:	
	Pnysician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	ne cause on each line.	a de la	lisease	.,9, 0001, 40 0.	arado or roopiidiory		l r	nterval Bety Onset and D	ween
	/Medical Examiner		resulting in death)	Due to (or as a consequen	ice f):	rije uje						
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ice of):							
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequen	ice of):							
9	.0 0 0	Physician/Medical	d	J		1707			p			
Вох	eath certif attending for use a	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de	ath 3	Ectopic pregnanc	y		23d. Dat Mor	te of delivery		rear
o.	at the death by the atterstached for	hysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	n 5L	Other (specify) _						
s, D	res that signed b	by P	Part II. Other significant conditions con	tributing to death but not resulting	ng in the ur	nderlying cause gr	ven in Part I.		tobacco use contr			
ord	w requir been si should l	Completed	Hypergension					L rabbet.	Yes 2 No	3 Probab		Jnknown
Be	The law te has age 2 a	ompi							opsy pormed?	Were autops prior to comp death? I ☐ Yes 2	pletion of ca	ause of
Vital Records,		Bec	25. Was case referred to medical examiner?					1 ☐ Yes of Death (Check only	-0	163 2		
		မ	1 Yes 2 No		Outpatien	I 3 DOA			idence 6 Other			
ion	ttending Ph death. ctor: After th t the funeral	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2. □N					
Division of	or Attenoration after death Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office			(Street and Number own, State)	er or Rural F	Route Numb	ber,
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	sicien: To the best of my knowle	dge, death	n occurred at the t	me, date and	place, and due to the	cause(s) and ma	nner as stat	ted.	
	To the Hospitel within 24 hours a To the Funeral I completely filled	ledicai	one)	ner: On the basis of examination and manner stated.	and/or inv			occurred at the time				1
\	To the vithin To the comple	Σ	29b. Signature and title of certifier	lef un		000	63593		29d. Date signed		ay, rear)	
,			30. Name and address of person who con	impleted cause of death (Item 23	Ba) (Type,	Print)	* / / /		~ / ~ / /	· /		
1	H-2		Mother Ginson	3 Byrkit 32. Registrar's Signature	Pr	Williams	port M	0 2/795				
	Sta Registr		31. Date filed (Month Cay Year) AR 0 0 20	07 Secur D	· De	rede						

Ammended #16a OKC 2/20/2007 Allegany County

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) 08237 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 17, 2007 **Physician** 13:50 Mildred Louise Snyder /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Frostburg Frostburg Village Nursing Care Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 X F 176-16-1319 85 October 22, 1921 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantrer must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Frostburg Maryland Allegany 10e. Street and Number One Kaylor Circle 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21532-Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 | Yes 2 No If Yes, Give / Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Mar No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemake homemaker 0 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) æ Edgar Weigand Clarabelle Paul ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard G. Snyder 316 Williams Street Cumberland Maryland 21502 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗷 Burial 2 □ Cremation 3 🗷 Removal from State February 20, 2007 Johnstown Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Forest Lawn Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** CARCINOMA Immediate Cause (Final disease or condition resulting in death) /Medical LUNG Examiner Due to (or as a consequence of Physician/Medical Examiner attending physician and for use as the buńal-transit Hospital or Attending Physicien: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DEMENTIA Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s certificate has b director, page 2 s 1 ☐ Yes 2 ☐ No 1 Tes 2 No within 24 hours after death.

To the Funeral Director: After this certific.

Completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Medical Certification: To 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier (Check only one) 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 2 of person who completed cause of death (Item 23a) (Type, Print)

Sidhu, M.D. 425 Bishop Walsh Rd. Cumberland, Maryland 21502 (2) UKC Italhu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rav 6/95

State Registrar 31. Date filed (Month, Day, Year)

FEB 2 0 2007

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Honth 726. Day Year **Physician** Charlotte Schaidt Marv 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours 212-24-2000 76 Director 04/24/1930 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygien i...
Important: If Item 27 Its marked outher than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified; MD Washington Hagerstown 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 713 Interval Road, #R 21740 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 III If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvia Edgar Knapp ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Interval Road, #R, Hagerstown, MD 21740 Barbara L. Bible / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet. Cem. @ Rocky Gap 02/20/2007 Flintstone, MD 4 Donation 5 Dother (Specify) 21. Signature of Fur ral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on , ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Has disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Obsta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed neumonia has been signed by the attending physician and ge 2 should be detached for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) □Yes 2□No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy After this certificate 2 No spital or Attending Physician: Theors after death.
neral Director: After this certificate y filled in by the funeral director, par 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 [1] Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 2-15-0 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 63 Wasiem 26 ool 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 08:30P M Clarence Joseph Stewart FEBRUARY 26, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CECIL VA MARYLAND HEALTH CARE SYSTEM PERRY POINT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1X M 2 □ F 214-16-8998 84 Director Aug. 6, 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 XIYes 2 □ No Director Maryland Cecil Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code e filed within 72 hours ofter death with all Hygiene. er other than "natural", or items 23a vent, the Medical Examiner must b 21904 U.S.A. 21 Center Street, P.O. Box 4 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1∑Yes 2 □ No
If Yes, Give
Year or Dates: 1943-46 Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Specify: þ Black 3⊠Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground Elementary/Secondary (0-12) College (1-4or 5+) Aberdeen, Maryland Entomologist one year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should le fi Department of Health and Menval H Important: If Item 27 Is marker oil any finury or other traumatic even once. Be Joseph J. Stewart Margaret Johnson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3924 Bush Court, Abingdon, Maryland Linda S. Robertson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 03/06/07 West Chester, Pennsylvania R.A. Ferris & Co., Inc. 21. Signature of Funeral Service Licen 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UNKNOWN CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AORTIC STENOSIS UNKNOWN Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ohysician and the burial-transit the death certificate be executed Due to (or as a consequence of): physician Physician/Medical as signed by the attending t be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident al or Attend after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

94/VA

29b. Signature and title of certifier

melle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division or Vital Records, P.O. Box 68760.

THOMAS S. MILLER, M.D. VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 32. Redistrar's Signature 31. Date filed (Month State

29c. License number

D30272

29d. Date signed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Feb. 22, 2007 **Physician** 11:55aM Nelson Santos /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) 10/26/1957 9. Birthplace (State or Foreign Country)
Brazil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 → M 2 □ F 49 Director 227-51-7601 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State show 1 ☐ Yes 2 No r 28a-f sh notified Silver Spring MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r 2507 Urbana Drive 20906 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married ¹x Yes 2□ No Specify: Brazilian Saltimore, Maryland 21215-0036 White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Shine Operator Shoe Shine Co. 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joaquin Ribeiro Dos Santos Leopoldina Dos Santos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 2507 Urbana Drive Silver Spring, Md. 20906 Flavia Dias De Oliveira/ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/05/2007 Beltsville, Md. Chesapeake Crem Funeral Service Lic Name and Address of Facilit 21. Signature PHILIP D.RINÁLDI FUNERAL SERVICE, P.A 9241 Columbia Blvd. Silver Spring Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Pre-existing cardiac disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of): burialphysician a Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. þ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has 1∏ Yes 2 **N**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 1 XYes _ 2 ☐ No မှ 28a. Date of Injury (Month, Day Year) 28b. Time of 27, Manner of Death 28d. Describe how injury occurred Certification: al or Attending P s after death. 5 Pending investigation 1 Natural 2 Accident Iniury 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb. 26, 2007 D 62175 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Glen Road Silver Spring, Md 20910 S. Gupta MD 1500 Forest 31. Date filed (Month, Day, Year) gistrar's Signatu State FEB 2 8 2007 Registrar

			1 - For State Registrar	State of M	larylan	-	artmen rtificate					Reg. No.	2007		8241
П	Physici	an	1. Decedent's Name (First, Middle, Las	corbly T	or.m.co	nd					2. Date of De Month	Day	Yee	r	Time of Death 3:43 M
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	Funeral		Social Security Number 6. Security Number		ge (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	iv. Year)	9. B	lirthplece Country)	(State or Foreign
	Director		Usual Residence of Decedent	⊠ M 2□F	64	Yrs.					Apr 14		42 P	enns	ylvania
	ow at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Ir	nside City Limits
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Baltimore,	permit. Pages 1 and 2 should Department of Heatth and Men Important: If Item 27 Is marke any injury or other traumatic 20028.		21. Signature of Funeral Service Licen	is-Migh	_M010										FH Inc. 21043
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<u>)</u>	12		30. Name and address of person who o	completed cause of	death (Item	4. 1	Print)	oth	De.	sta	100	J.	hier I	an	21045
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}	Examir	er	4a. Facility Name (If not institution, giv				ity, Town, o Bethe	r Location of Deat	h		County of Deat	
48	Funeval		Suburban Hospita 5. Social Security Number 6.5		e (In yrs. last birthe		der 1 Year	If Under 24 Hrs.	8. Date of B	irth		thplace (State or Foreign
ь	Funeral Director			M 2□F	70 Yr	Month	ns Days	Hours Min.	(Month, D	ay, Year) 15, 1	936 In	ountry) can
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	ar Location						10d. Inside City Limits
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9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \)	Ever in U.S.		cedent of F pecify Cub	dispanic Origin? (S an, Mexican, Puer Specify:			14. Race - Ame Black, Whit	erican Indian,
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-	600		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the death. Do no	t enter the n	node of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between
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	2	99	30. Name and address of person who					. "	0 = -		ATT CCC	250
		111	George A. Sotos, 31. Date filed (Month, Day, Year)		7 Medical	L Cent	er Dr	rive, #30	U Rockv	ılle	, MD 208	350
	Sta Registi		FEB 2 8 200		ar's Signature	ask)						

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra attending physician a for use as the burial Division or Vital Records, P.O. Box 68760, certificate this I Director: / within 24 hours a

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified

Important: If item 2 any Injury or other

Physician /Medical

> 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 0060100 02-23-7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K AHMED TAHMINA Universup BIVE EagL Ver Spun MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2007 MAR 0 1

State Registrar

			1 = For State Registrar	State of M	larylan				ealth a Death		_	giene Reg. No	21111	0824	
¥	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of Dea	ath Da	y Year	3. Time of Deat	h
	/Medic		Anna		aulin	ie		righ			Februa	ry	14, 2007) M
33	Examir	er	4a. Facility Name (If not institution, given		-)		4b. City		Location o			4c.	. County of Deat		
			13118 Bedford 1 5. Social Security Number 6.5		ge (In ure I	last birthday)	If I Inde	Cumber 1 Year	erlan		8. Date of Birt	h	Alleg	, ,	
	Funeral Director			1 ☐ M 2 ☐ XF	78	Yrs.	Months		Hours	Min.	(Month, Da	y, Yea <i>r)</i>	Co	hplace (State or Fore untry)	-
			Usual Residence of Decedent				J.,				01/21/	192	west	Virginia 	
	how	_	10a. State 10b. County		10c. City	, Town or Lo								10d. Inside City Lim	
	8a-f	Director	MD Alle	gany				mber]	land					1 ☐ Yes 2 ☐	No
	with the	D	10e. Street and Number		,		10f. Zi	p Code				10g. Cit	izen of What Co	untry?	
	s 23c	era	13118 Bedford	12. Was Deceden		6 12	Man David		502	=i=2 (C==	air. Van as Na		USA 14. Race - Ame	riona Indian	
	fter d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marned	Amed Forces	?	3. 13.	If Yes, spe	cify Cuba	n, Mexican	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White		
036	at', or	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 X №	Specify:				Specify: W	hite	
2-0	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow Ite Madical Erain or tries for multied at	Completed	15. Decedent's E (Specify only highest gr			16a. Dece			ation furing most	t of worki	na	16b. K	ind of Business/	ndustry	
7	ithin	du	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	ise retired,)	O WOTAT	.9				
12	filed w Hygier other th		12 17. Father's Name (First, Middle, Last			Nı	ırsin	g Ass	sista				dospital		
anc	i be fi	Be	Arthur			0-41					(First, Middle,				
Ž	2 should be and Mental I marked o	T ₀	19a. Informant's Name/Relationship	Ding	es	God]		c (Stroot a		rcie	E11		Wils		
Maryland 21215-0036	U 40 = 40		John E. Wright /										Land, MD		
d)	thealth Health Item 27 othar tr		20a. Method of Disposition	nasbana	20b. Pi	ace of Dispo	sition (Na	me of	- 1		ate Cull		cation - City or		
Baltimore,	permit. Pages 'Department of the Important: If Ite any injury or ot once.		1 X Burial 2 ☐ Cremation 3 E 4 ☐ Donation 5 ☐ Other (Specia		4	ametery, crer set Me	-		-	2/18	3/2007	Cu	mberlan	d. MD	
alti	partm sorts / inju		21. Signature of Funeral Service Lice	• • • • • • • • • • • • • • • • • • • •										Home, F.	4 -
m	Depa Impo any ir		Kalt C. Ale	Q 1			404 I	Decat	ur St	reet	, Cumbe	erla	nd, MD	21502	
· · · · · · · · · · · · · · · · · · ·	Physician // Medical Examiner Physician and / Physicia	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a: Due to (or a: Due to (or a:	s a consequ	rence of):	- Lu	ug (ance	ee				Onset and Death	
P.O. Box 68	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25000 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	DEctopic p Other (s)						23d. Date of deli Month	very Day Year	
rds, F	w requires that sheet sheet should be de	þ	Part II. Other significant conditions	contributing to death	but not resu	Iting in the u	nderlying (cause give	in in Part I.		23e. Did to			the cause of death?	
		Completed									24a. Was a autop perfor 1 🗆 Yes	SV	24b. Were aud prior to death?	topsy findings availa ompletion of cause of	ble of
Vit ²	ifcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Liceritati				101		of Death	(Check only di	nel		/	
ot	Physical direction	. To	1 Yes a No	Hospital:		R/Outpatien			4 🗀 1901	rsing Hon			6 ☐Other (Spec	nfy)	
L _O	ding h. After funer	i i	1 Natural 5 Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	м	28c. Injury Work	at ? ′es 2.∐.N		8d. Describe h	ow injur	y occurred		
Division	To the Hospital or Attending Physician: within 24 hours after death as the teath To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In	jury - At hor tc. (Specify	me, farm, str			65 2		8f. Location (S City or Tow			ral Route Number,	
	Hospitat or 24 hours afte Funeral Dir tely filled in	sal (29a. Certifier (Check only Medical Example 1) Medical Example 1	nysician: To the best	of my knov	vledge, death	occurred	at the time	e, date and	d place, a	and due to the o	ause(s)	and manner as	stated.	
	the H in 24 the Fi pletei	ledical	one) Medical Exam	niner: On the basis of and manner s	or examinati tated.	on and/or in	estigation/	ı, ın my ap	inion, deat	n occurre	at the time, o	date and	place, and due	to the cause(s)	
	To the within 2 To the complet	≥	29b. Signature and title of certifier				29	c. License			· ·		te signed (Month		
			How Dlew	MI)				D463	346			Feb	oruary 1	5, 2007	
	200		30. Name and address of person who Huma Sh'akil					C	nhow1.	224	MD 01	E O O			
(62)	CT-0.51		31. Date filed (Month, Day, Year)		rar's Signat	ent Av	enue	, cum	inei,Tg	anu,	מט 21	502		1	
1	Sta Registr			2007	.a. a aigilati	lo.	-							1	

ORIGINAL

		•	For State Registrar	State of Ma	aryland /		artment of				iene _{eg. No.}	ere :	08245
	Physici	an	1. Decedent's Name (First, Middle, Trilba	_{Last)} Juani	ita		Wagor	er		Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,				4b. City, Town		on of Death	Februai	4c. County	2007 of Death	1930 P M
	Examin	er	Allegany County		Rehab	Ctr.		erlan				llega	any
	Funeral Director			S. Sex 7. Ag	e (In yrs. last t		If Under 1 Ye Months Da	ar If Und	ler 24 Hrs.	8. Date of Birth (Month, Day 08/09/	Yearl	9. Birthp Cour	lace (State or Foreign
	put 🔏		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					1	Od. Inside City Limits
	Maryla f sho	o	WV Mine	. w. a. 1	100.019, 10		t Ashby					'	1 □Yes 27 No
	r 28e-	Director	10e. Street and Number	rai		101	10f. Zip Cod			1	0g. Citizen of V	/hat Cour	ntry?
	th with	al D	Route 963, Wag	goner Road	(P.O.Bo	x67	1) 2	26719			USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any figury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 Yes 2 1 1 Yes, Give Year or Dates:			Was Decedent of Yes, specify C			ecify Yes or No- Rican, etc.)		k, White,	ean Indian, etc. nite
21215-0036	2 hou	ted	15. Decedent's	Education	16	a. Dece	tent's Usual Oc kind of work do	cupation	ant of work	ina	16b. Kind of Bu		
21,5	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	DO NOT use re	ired)	IOSI OI WOIK	ng .			
2	Hygier Hygier ther ti	S	12 17. Father's Name (First, Middle, La	ast)			Secretai		ther's Name	(First, Middle,	Medi Maiden Sumam		
Maryland	ld be l ental l ked o ic eve	To Be	Arthur	Eugene	Wh	isne	er		Ethel	(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(NMN)	-,	McCoy
ary	shou and M smar	-	19a. Informant's Name/Relationship	o (Type, Print)	19	9b. Mailir	ng Address (Str	et and Nur	nber or Rura	al Route Number	; City or Town,	State, Zip	Code)
	and 2 lealth m 27 i		Alden E. Wagone	<u>er / husban</u>						hby, WV		- T	
Ore	tges 1 nt of H : If ite or otl		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3		1		sition (Name of natory or other		1		20c. Location -	•	
Baltimore,	artmer ortant Injury	-	* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Li		Rest1					7/2007 ams Fami			Home, P.A.
Ba	Depar Depar Impor any Ir		talet C.	Solum ()					, Cumber	-		21502
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused	the death. Do	not ent	er the mode of	tying, such	as cardiac (or respiratory arr	est,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition resulting in death)		many	an		1 Sea				101	Onset and Death V r
В	/Medical Examiner			Due to (or as	a consequenc	e of):	11					1	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin	b. Due to (or as	a consequence	e of):	100			7 7 - 1		-	
	ecuted and -transi	Examiner	cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last	C	a consequenc	o of\:							
8760,	cate be executed physician and the burial-transit	dicai E		Due to (or as	a consequenc	a 01).							
9	tificate ig phy: as the	ledic		u							1.00		61
Вох	leath certifica attending pt d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregna Other (specify				23d. Dat Mor	e of delive nth	ery Day Year
o.	that the di ed by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									_
Vital Records, P	es gu	by	Part II. Other significant condition	s contributing to death b	ut not resulting	in the u	nderlying cause	given in Pa	rt I.	23e. Did to	43	ibute to th 3 🗌 Prob	ne cause of death?
eco	e law requir has been si je 2 should	Completed	- Drahetes	Mellitis.						24a. Was a	n 24b. V	Vere auto	psy findings available mpletion of cause of
<u>~</u>		Con								perfor	myed? c	leath?	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor		(Check only or			
o	Phys or this oral di	7. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ent 2 ER/0	. Time of	I 3 DOA	njury at Vork?		me 5 🗌 Resido 28d. Describe ho			y)
ion	Attending ir death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		y Year)	Injury		Vork? ☐ Yes 2	□No				
Division	ol or Attending is after death. I Director: After d in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, c. (Specify)	farm, str	eet, factory, offi	Ce Ce		28f. Location (S City or Tow		er or Rura	ll Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai C		Physician: To the best Paminer: On the basis of and manner st	f examination a								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Jy h				ense numbe		2	9d. Date signed		
								3328	U		teb 15	,20	JU /
	40		30. Name and address of person w					7 1	.1	MD 01	F00		
	Sta	te	Sunil Gup: 31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		renue, (Lumber	·land,	MD 21	502		
	Registr	ar	FEB 1 6	2007	Esser Si	K A	parle						

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			For State Registrar		,	State	ot Ma	arylan					lealth D <i>eath</i>		lental H	ygien Reg. N	20	0.7	08246
			Decedent's Name	e (First, Middle	, Last)										2. Date of D	eath	ay	Year	3. Time of Death
	Physicia /Medic				Mary	Velo	la W	are							Februa	ary :	28 2	007	10:30 P ^M
4	Examin	er	4a. Facility Name (/		, give str	reet and nu	ımber)						Location	of Death		4	c. County	of Death	•
.ved-r	Funeral		5. Social Security N		6. Sex		7. Ag	e (In yrs. i	last birth		If Under	1 Year	If Unde	r 24 Hrs.	8. Date of B	irth		9. Birthp	lace (State or Foreign
ш	Director		228 14 4	1526	1 🗆 1	VI 2.1X.) F	8	8	Υ	rs.	Months	Days	Hours	Min.	Jan 2	7, 1	919	Vir	ginia
	and ww		Usual Residence of 10a. State	Decedent 10b. County				10c. City	y, Town	or Loca	ation							1	0d. Inside City Limits
	Maryl I-f sho fied a	tor	MD	Montq	omer	v		Silv	ver	Spr	ina								1
	th the or 28a e noti	Sirec	10e. Street and Nu			4			<u> </u>		10f. Zip	Code					itizen of W		-
	s 23a	ral	15617 нс	olly Gr						40.14		0905					nited		tes an Indian,
_	ter de ritems iner n	Funeral Director	11. Marital Status 1 ☐ Never Marr	ried 2□ Marr		2. Was Dec Armed F 1 \(\supers	orces?		S.	13. W	as Deced Yes, spe	cify Cuba			ecify Yes or N Rican, etc.)	10-		k, White,	
215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	₹ Widowed			If Yes, G Year or I	ive			1	Yes	≱ [☐ No	Specif	y:			Specify:	W	nite
о Р	72 ho 'natur	Completed	(Spec	15. Deceden)		16a. [Decede Give k	nt's Usua ind of wo	al Occup	ation during mo	st of work	ing	16b.	Kind of Bu	siness/In	dustry
2121	e filed within 72 h ul Hygiene. other than "nati rent, the Medica	Jup	Elementary/Seco	ondary (0-12)		College	(1-4or 5	+)			emak		"				Own :	Home	
מ פ	illed Il Hygi other ent, t	Be C	17. Father's Name	(First, Middle,	Last)					11011			18. Moti	ner's Name	e (First, Midd	le, Maide			
<u>Jar</u>	should be filed ind Mental Hygi marked other umatic event, t	To B	Howard W	Vard Wi	lson								Eth	el Le	e Sibl	Ley			
Maryland	ar ar		19a. Informant's N		nip <i>(Typ</i> €	e. Print)			1						al Route Num				
	1 and 2 Health tem 27 is		John War 20a. Method of Disp					20b. P			tion (Nar	Pk			Silver	-	ring, Location -		
آ ا	Pages nent of nt: If It		1 ☐ Burial 2 4 ☐ Donation			moval from	State				atory or o mato		1	3-1-2	2007	Cat	tonsv	ille	MD
Baltimore,	permit. Pages Department of Important: If It any Injury or o		21. Signature of Fu			1118	00	M010											ily FH Inc.
m	e a E E E		Min	1 Coll	ms -	-uJ	Thy			41	<u>12 0</u>	<u>1d C</u>	olum	bia I	Pike El	llic			MD 21043
			23a. Part1. Enter t shock, or hea Immediate Cause	art failure. List	only one	ations that cause on	caused each lir	the deathne.					i	is cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Deam
5	Physician /Medical		disease or condition resulting in death)	חמו	a.	Due to	(or as	a conseq	•		wo	w	4						- Lady
A.	Examiner		Sequentially list co	anditions	b.			·											
	pe sit	iner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	2		(or as	a c <i>o</i> nseq	uence of	f):									
Ö,	e executed ian and urial-transit	Examiner	that initiated events resulting in death)	S	c.	Due to	(or as	a conseq	uence of	f):									
1,60	ysician	_			Cd.														
x 687	death certificate be attending physicia for use as the bur	Physician/Medica	IF FEMALE:		000	a 16 v.a.a. av	,tooma												
Box	attend for us	cian/	23b. Was deceden	months?	230		birth	pr pregna 2 Feta time of d	l death		Ectopic p		/				23d. Date Mor	e <i>o</i> f delive nth	ery Day Year
Ö.	at the de by the a tached	hysi	1 ☐ Yes 2 € 9 ☐ Unknown			9□Unk					(-,								
S, P	w requires that s been signed b should be deta	by P	Part II. Other signi	ficant condition	ons conti	ributing to	death b	ut not resi	ulting in t	the und	derlying o	ause giv	en in Par	II.					ne cause of death?
ord	requir een s hould			\mathcal{A}	en	Leni	ney	00	ny	M	11/21	50	0	1100					ably 4 □Unknown
Records,	sician: The law certificate has b irector, page 2 s	Completed						DU		7	, 01				24a. Wa aut per	topsy rformed?	p	prior to co death?	psy findings available mpletion of cause of
Vital	an: T tificate tor, pa	Be Co	25. Was çase refe	rred to medica	i							-	26. Pla	ce of Deat	1 Yes h (Check onl)		10 1	Yes	2 No
<u> </u>	hysici his ce I direc	To B	examiner?		Ho] Inpatie		ER/Outp				4	Nursing Ho	ome 5□Re	sidence	6 □Othe	er (Specif	y)
o U	ding Phy h. After thi funeral		27. Manner of Deat	5 Pendin		28a. Date (Mo	of Inju nth, Da	ry y Yea <i>r)</i>	28b. Ti inj	me of jury	M	28c. Injur Wor	yat k? Yes 2[JNo.	28d. Describ	e how in	ury occurr	ed	
Division or	Attence death	ficat	2 Accident 3 Suicide	investi 6	not be	28e. Plac	e of inju	ury - At h	ome, farr	m, stre				_140				er or Rura	Route Number,
á	tal or s after al Dire	Certification:	4 Homicide			Dulk	aing, et	c. (Specif	y) 						City or I	own, Sta	ite)		
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bure	Medical	29a. Certifier (Check only one)	1 Certifyir 2 Medicai			basis o	f examina							and due to the				
	To the within To the comple	Σ	29b. Signature and	d title of certifie	71	ya	M	. /	the		29	c. Licens	e numbe	200	40	29d. [Date signed	(Month,	Day, Year)
10	a2		30. Name and add	uy s	uj	npleted cau	ise of d	eath (Iten	n 23a) (T	ype, P	rint)	ha	ue	Cu	4D	tig	upir	la	40
1	Sta Registr		31. Date filed (Mor	MAR 0		32.	Rygistr	ar's Signa	ture										2 (228
	riogisti			man V A	, <u>LU</u> L	1		- L	~	Age !	BULL	,							

			For State Registrar		State of	Marylar		artment o			ind M		giene Reg. No	2007	08	247
			1. Decedent's Name	(First, Middle, L	ast)							2. Date of Dea	ath			of Death
	Physici /Medic		Alice	Walt	ers							Month March 1	Da	у Үөа 2 0 07	5:05	РМ
	Examin		4a. Facility Name (If	not institution, gi	ve street and numb	er)		4b. City, Tow	m, or L	ocation of	f Death		40	. County of De		
		1			ing Home			Bradd						Frede		
	Funeral		5. Social Security No. 213-22-39		Sex 7. 1 □ M 2 □ F	Age (In yrs. 93	last birthday) Yrs.	If Under 1 You Months Da	ear ays	Hours 1	Min.	8. Date of Birt (Month, Day	y, Year)	1	irthplace (State Country)	
	Director		Usual Residence of			93		L			No	vember	1,	1913	Marylar	ıd
	yland Jow		10a. State	10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside	City Limits
	e Man	ctor	Maryland	Frederi	ck	Bru	ınswick	C							tx⊡Ye	es 2□No
	ith th or 28	Director	10e. Street and Num					10f. Zip Cod					•	tizen of What	Country?	
	ath w			Avenue				2171						JSA		
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, Ite Medical Examinst must be notified at	/ Funeral	11. Marital Status 1 ☐ Never Marrie	_	12. Was Decede Armed Force 1 Yes 2 If Yes, Give	es?		Was Decedent If Yes, specify (1 ☐ Yes 2☑	Cuban,	panic Orig , Mexican, Specify:	in? (Spe Puerto f	cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wi Specify: W		
21215-0036	hours urel',	Completed by	3 🛚 Widowed		Year or Date	s:										
5	n 72 "nat	lete		15. Decedent's E fy only highest g			(Give	dent's Usual Oc kind of work do DO NOT use re	on <i>e d</i> u	ion <i>ring m</i> ost	of workir	ng	16b. K	and of Busines	s/Industry	
72	iene.	шо	Elementary/Secon	ndary (0-12)	College (1-4	or 5+)		y Techi	,	ian			U.S	G. Gove	rnment	
פַ	illed Hygid other	Be C	17. Father's Name (First, Middle, Las	t)				1	18. Mother	r's Name	(First, Middle,	Maider	Surname)		
Maryland	2 should be and Mental I s marked o	To B	John Thon	nas Stew	art				1	Amand	la Di	ehl				
Man	2 sho and Is ma		19a. Informant's Na					ng Address (Str						·		
	1 and 1ealth sm 27 ther t		Sherman V		- nephew		- Committee of the comm	9th Ave		e, Br		71CK, Ma ate			1716	
altimore,	Pages nent of h ant: If its ary or o		'	Cremation 3	□Removal from Sta	ate C	emetery, crei	matory or other	place)	- 1	-7 - 20			ocation - City o		
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre		21. Signature of Fur	neral Service Lice	ensee	0		2. Name and Ad			DLO	uffer I				21702
			23a. Part1. Enter th	e disease, or cor	nplications that cau	sed the deat								ick, na	Approxim	ale
	Physician		Immediate Cause (I	-inal	one cause on eac	n iine.	00	2920							Interval B Onset an	d Death
	/Medical		resulting in death)	-	a Due to (or	as a cons	_	arch.							Mos	44/2
В	Examiner		Sequentially list con	ditions	b											
	sit sit	Examiner	if any, leading to im- cause. Enter Under Cause Lisease of	mediate lying	Due to (or	as a conseq	uence of):									
_	and I-tran	хап	that initiated events resulting in death) L		c. Due to (or	as a conseq	neuce ot).					_				
8760,	cate be executed ohysician and fhe burial-transit	dlcalE		l												
687	ificate g phy: as fhe	edlo			0.											
Box	leath certific attending p	N/U	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome			7F-4						23d. Date of d	elivery	
	that the death led by the atten detached for u	by Physiclan/Me	in the past 12 r 1 ☐ Yes 2 🖼		1∐Live birth 4∐Pregnan 9∐Unknow	t at time of d		Ectopic pregna Other (specify						Month	Day	Year
0.	at fhe	Phy	9 Unknown									7				
Vital Records,	The law requires that the death certifinite has been signed by the attending prage 2 should be detached for use as		Part II. Other signifi	cant conditions	contributing to deat	n but not res	ulting in the ui	nderlying cause	given	in Part I.			bacco (use contribute		death? Únknown
Ö	w requir been s should	Completed										24a. Was a	an.	24b Ware	autopsy finding	s available
Re	The lav	ошо										autop. perfor	sy med?	prior to death?	completion of	cause of
ā		0	25. Was case referre	ed to medical					2	26. Place	of Death	(Check only or	2 No	1 LI Y 6	s 2 No	
	S S	To B	examiner?	, 10	Hospital:	atient 2 🗆	ER/Outpatien	t 3 DOA	Other:			ne 5 ☐ Resid		6 □Other (Sp	ecify)	
ПО	ding Phy J. After thi funeral o		27. Manner of Death	5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c. l	njury a Work?			8d. Describe h				
<u>S</u>	Attending or death. ector: After by the fune	catle	2 Accident	investigation	on					s 2 🗆 N	lo					
Division of	or Attencater death after death Director: in by the	Certification;	3 ☐ Suicide 4 ☐ Homicide	determined	286. Place of	etc. (Specify	ome, farm, str y)	eet, factory, offi	ice		2	8f. Location (S City or Tow	treet ar n, State	nd Number or F e)	Rural Route Nu	mber,
_	Hospital or A 24 hours after 8 Funeral Dire etely filled in by		29a. Certifier	Certifying P	hysician: To the be	et of my kno	wladaa daath	a good at the	o timo	data and	I place a	nd due to the	2000(0)	\ and	a state d	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one)	2 Medical Exa	miner: On the basis	s of examina	tion and/or inv	vestigation, in n	ny opir	nion, death	occurre	d at the time, o	ause(s)	d place, and du	is stated. ie to the cause	(s)
	To the within 2 To the complet	Me	29b. Signature/and t	itle of certifier				29c. Lic	ense r	number		2	29d. Da	te signed (Mor	nth, Day, Year)	
)			1	Culi	Lot .	shall	to	m	0,	050	280	10	3	12/2	507.	
	6		30: Name and addre	ss of person who	completed cause	of death (Item	1 23a) (Type,	Print	Λ					1	71	71/
			31. Date filed (Monti	Day Year)	62264	strar's Signa	1		1	sen.	ue_	Pea	0,20	N 2/2.W	יוט עי	110
	Sta Registra		CT. Date filed (MONII	MAR 0 2	2007	arar s signa	J. A.	parli								

				Department of Health and M Certificate of Death		iene	07	082	1.8
H	Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h Day	Year	3. Time of	Death
	/Medi		Olga N. Yursis		Februar	y 28	2007	8:00	A M
	Examir	ner	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			ty of Death		
- 3			5516 Barrington Court 5. Social Security Number 6. Sex 7. Age (In yrs. last bin	Columbia thday If Under 1 Year If Under 24 Hrs.	8. Date of Birth	How	ard	olace (State o	e Famion
	Funeral Director		104 375	Months Days Hours Min.	(Month, Day, July 23	Year) , 1954	Coui	aine	roraign
	pu ,		Usual Residence of Decedent		002, 20	7_10.			
	death with the Maryland ms 23s or 28s-f show Imust be natified at	5	10a. State 10b. County 10c. City, Town				1	l0d. Inside Cit 1 ☐ Yes	1111
	the M	Director	MD Howard Column 10e, Street and Number	bia 10f. Zip Code		og. Citizen of	140-1-0-1-		2 140
	With The		5516 Barrington Court	21045				•	
	death ms 2:	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto			ice - Americ	an Indian,	
٥	after or Ite		1 Never Married 2 Married 1 Yes, Give	_	Rican, etc.)		ack, White,	etc.	
0030	ural',	d by	3 ☐ Vidowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 🌠 No Specify:		Speci	Whi	te	
Ç	n 72 h	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workit life. DO NOT use retired)	ng	16b. Kind of I	Business/In	dustry	
7 7	withi iene. than	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Manager		Reta	: 1		
	Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N				
Iana	Alenta Alenta rked tic ev	To B	Andrei Nazarenko	Tatiana Z	agornaya	a			
Mar	is 1 and 2 should be filed within 72 hours after death with the Manylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event. It a Medical Examinating must be instilled as			Mailing Address (Street and Number or Rura					
C, E	and ealth m 27	١,		ese & Carney 10715 Ch	the state of the s	r. Ste	200 (Columb	ia,MD
9	ges 1 t of H Mite		1 Burial 2 XCremation 3 Removal from State	y, crematory or other place)		20c. Location			
paitimor	t. Partmen rtant:			Crematory 3-1-2		Catons			
Da	permit. Pages 1 an Department of Heal important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee M01044	22. Name and Address of Facility Har 4112 Old Columbia P	ry H. W	itzke': icott (s Fam: City,	ily FH MD 210	Inc. 043
	Physician		23a. Part i. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	not enter the mode of dying, such as cardiac or Sav Co ma	r respiratory arre	st,		Approximate Interval Betwood Onset and D	veen Death
	/Medical		resulting in death) a. Due to (or as a consequence of				عا	mon	נאז
	Examiner		Sequentially list conditions.						
A STATE OF	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):					
•	icate be executed physician and s the burial-transit	xan	that initiated events resulting in death) Last	of):					
g,	e be e siciar suria	dicai E		•					
0	ificate g phy as the	ledic	0.						
5	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Da	ate of delive	ry	
	the att	sicis	1 Yes 2 No	5 Other (specify)		M	onth	Day Y	ear
	that the d	Phy	9 Onknown						
n n	uires tha signed I d be det	l by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		~	tribute to th	e cause of de	
5	v requii been s should	etec			1 🗆 Ye		3 [7100	abiy 4	nknown
ב	ne lav e has ge 2 :	Completed			24a. Was an autopsy perform	.	Were autor prior to con death?	osy findings a npletion of ca	vailable use of
9	ician: The certificate ha	ပို	25. Was case referred to medical		1□ Yes 2	XNo		2 N o	
>	ysician: Is certific director,	OB	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Out	26. Place of Death patient 3 DOA Other: 4 Nursing Hom			(0		
5	g Phy ter thi neral o	T: U	27. Manner of Death 28a. Date of Injury 28b. Ti	ime of 28c. Injury at 2	8d. Describe how			7	-
2	tanding I seath. tor: After the funer	atio	2 Accident investigation	njury Work? M 1 ☐ Yes 2 ☐ No					
2	l or Attandi after death. Director: A i in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office 2	8f. Location (Str. City or Town,	et and Numi State)	ber or Rura	Route Numb	er.
ב	oital c urs af oral D		-						
	in the Hospital or Attanding Physician: within 24 hours after death carefulling the funeral Director: After this certification for the Funeral Director; and properties of the funeral director; and the	edical	29a. Certifier (Check only one) Check on Check	death occurred at the time, date and place, a for investigation, in my opinion, death occurre	ind due to the car ad at the time, da	use(s) and m te and place,	anner as sta and due to	ated. the cause(s)	
	To the within To the complete	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signe	d (Month, L	Day, Year)	
) V3 (Inc. 1)	241139		March	1. 20	07	
aio	>		30. Name and address of person who completed cause of death (Item 3a) (1	Type, Print)		14 1	11	1	7
	Sta	te	31 Date filed (Month, Day, Year) 32. Agistrar's Signature	11065 Little Matu	xect 1	Kuy (DIMA	The Designation	104
	Registr	ar	MAR 0 2 2007 Street &	Soule		0			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 0555AM Walter Ash MAR 06 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner ST AGINES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 212-40-0866 Director 65 Jan 10, 1942 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1√Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Millington Avenue Funeral 21223 filed within 72 hours after death USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify. þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) cab driver transportation permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ash Ethel Hienlein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Goldie McNamara/sister 820 Caton Avenue #9K Baltimore, MD 21229

of Disnosition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature Funeral Stryice Licensee Romal d S. Wade Director Baltimore, MĎ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPOXIC ENCEPHALOPATHY Physician 7 days /Medical Due to (or as a consequence of): Examiner ARDIDFULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): 0 WE burial-trar Box 68760, attending physician Physician/Medical RATE the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Day Month Year 5 Other (specify) P.0. signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by ARDIOMYOPATHY 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1□ Yes 2/No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐/No Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A324385283699 MAR, 06, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOSPITAL, 900'S CATON AVE BALTIMORE AGNES MANISH SINGH 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-01850 Reuben Edward Alley, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Reuben E. Alley, Jr. Medical Examiner March 8, 2007 Rueben Edward Alley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 299 Halsey Road Annapolis Anne Arundel 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) Director Months Days Hours 229-16-4417 88 1 X M July 16, 1918 Yrs Usual Residence of Decedent any 10c. City, Town or Location MD s 23a or 28a-f show e notified at once or 28a-f show Anne Arundel Annapolis death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 299 Halsey Road 21401 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, other than "natural", or items the Medical Examiner must be 2 X Married Armed Forces? if Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 1 X Yes 2 Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. If Yes, Give Year 44-46 Widowed Divorced 1 Yes 2X No specify: Specify: 3 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Mrdiral 12 5+ college professor education 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) t: If item 27 is marked other traumatic event, t Be Reuben Edward Alley Mary Elizabeth Sutherland 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Tanglewood Drive Barrington, RI Robert Alley/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) Burial 2 Cremation 3 Removal from State X Donation 5 Other Specify Service I Renard Service I State Anatomy Board 655 W. Baltimore Street

3. Time of Death

2325 hrs

CountrWirginia

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Death

Nursing Home 5 Residence 6 Other: Scene

28f. Location (Street and Number or Rural Route Number, City

March 9, 2007

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred Victim of house fire

or Town, State) 299 Halsey Road, Annapolis, MD

Birthplace (State or

oreian

white

Physician /Medical Examiner

Part I Enter the

Immediate Cause (Final disease

or condition resulting in death)

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated

Sequentially list conditions,

examiner?

1 V Yes

27. Manner of Death

Natural

Suicide

Ling Li, MD

Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

eilure. List only one cause on each line

a Smoke inhalation

Hospital: 1

5 Pending

Investigation

30. Name and address of person who completed cause of death (Item 23a)

6

Assistant Medical Examiner

Could not be

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Inpatient 2

(Specify) Single Family

32. Registrar's Signature

28a. Date of Injury (Month, Day, Year) FOUND:

Mar 8, 2007

and manner stated

mid

After this certificate has been signed by the attending physician To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi

Division of Vital Records, P.O. Box 68760,

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he tuneral director, page 2 should be detached for use as the bunal - transit	ion: To Be Completed by Dhysician/Medical Evamine
7	1 6
page	5
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je.	:

Medical

State

Registrar

	events resulting in death) Last	ue to (or as a consequence of):				
	dUNPENDED	AMENDED #1, perME, G865, 3/16/07 TT			_	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		23d. Date of o	delivery Day	Year
•	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		2 No 3	Probably 4	4 Unknown
			24a. Was an autopsy performe	pr ed? de		indings available ion of cause of 2 \textstyle No
	25. Was case referred to modical	26 Place of Death (Check only	one)			

ER/Outpatient 3

28b. Time of Injury

FOUND

2325 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc.

MD

Other₄

Yes 2 V No

28c. Injury at Work?

DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

111 Penn Street, Baltimore, MD 21201

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

DHMH 17 Rev 1/2001 OCMF 2006

07-01857 Helene Alley Me

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State	of	Maryland	/ Department	of	Health and	d Mental	Hygien
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		1- For State Registrar	Certifica					. No. 21	07. 0825	
Physici dical Exami		1. Decedent's Name (First, Middle,Last) Helene Alley					2. Date of Death Month March 9, 20		3. Time of Death 1108 hrs	
,		4a. Facility Name (if not institution, give street and number)	· · · · · · · · · · · · · · · · · · ·	4b. City	, Town, or Lo	ocation of Deat		4c. County of Dea		
		Johns Hopkins Bayview Medical Center		Balt	timore					
Funeral Director		143-16-2074 1 M 2XF	In yrs. last birtho		nder 1 Year nths Days	If Under 24Hr Hours Min		. 1	Birthplace (State or Foreign Country) New Jersey	
s after death with : rral", or items 23: niner must be not	tor	MD Anne Arundel	Oc. City, Town or	napolis					10d. Inside City Limits 1 Yes 2 No	
	I Director	10e. Street and Number 299 Halsey Road		10f. 2	Zip Code	21401	10g	i. Citizen of What Co USA	ountry?	
	r Funeral	11. Marital Status Never Married Never Married Married Armed Forces? Yes Widowed Divorced If Yes, Give Year	ver in U.S.	If Yes, spe		Mexican, Puert	Specify Yes or No- o Rican, etc.)	White, etc.	erican Indian, Black, vhite	
	Completed by	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+	ىلە كىسى	ecedent's Usu	al Occupatio	n (Give kind of DO NOT use re		16b. Kind of Busines		
within grene.	omp	12 2 17. Father's Name (First, Middle, Last)			medical secretary			healthcare rst, Middle, Maiden Surname)		
at Hyg	Be C	Theodore Whitlock			18		e (First, Middle, Ma Ethel Wei	•		
212 Suld be Ment mark ic ever	ТоВ	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Addre	ess (Street			er, City or Town, Sta	ate, Zip Code)	
MD d 2 sho tth and n 27 is numat	i	Robert Alley/son	2	2 Tang1	.ewood	Drive	Barringt		2806	
imore, Pages I and nent of Heal ant: If item or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify:	20b. Place of cremator	Disposition (N y or other place		etery,	Date	20c. Location - City	or Town, State	
		JANN / / O Call	ator	State Baltir		my Boar		Baltimor		
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Thermal injuries Approximat Between O Death of the de								
P.O. Box 68760, so that the death certificate be execut gred by the attending physician and edeached for use as the burial - tra-	er	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
	Medical E	1								
	sician/	23b. Was decedent pregnant in the past 12 months?	4 Pregnant at time of death 5 Other (Specify)						ery Day Year	
	d by Phy	1 Yes 2 No :							to the cause of death?	
of Vital Records, g. Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed						24a. Was ar autops perform 1 Yes 2	y prior t ned? death	autopsy findings available to completion of cause of caus	
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical examiner?				of Death (Check	k only one)			
F Vil Physic ar this	힏	1 Yes 2 No		patient 3				Residence 6 Ott	ner:	
Division of tal or Attending P rs after death. Tal Director: After led in by the funera	ertification:	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injury FO(Not)b. Dey Yea Mar 8, 2007	FOUN 2325 I	hrs		s 2 V No	Subject victin	ow injury occurred n of house fire		
Division Hospital or Attence 24 hours after death Funeral Director:	0	3 Suicide 6 Could not be determined (Specify) Single Family Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred					or Town, Sta 299 Halsey Roa	Road, Annapolis, MD		
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	2	29b. Signature and title of certifier		29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) March 10, 2007		
		0. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201								
St Regist		31. Date filed (Month, Day, Year) NAR-1 6 2007	Signature	els!						

DHMH 17 Rev 1/2001 OCME 2006

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DHMH 17 Rev 1/2001

Registrar

State Registrar 31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

December Name (Pietr Months (1996) Provided December (Pietr Months) Prov				For State	State of Ma	ryland / [Department of F Certificate of		Mental Hy	•	21111	1 08	254
Private Priv			7.7	Registrar 1. Decedent's Name (First, Middle, Lat	st)		Certificate of	Dealli	2. Date of D		0/ 0 0 /	3. Time o	f Death
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Physician Medical Examiner Template Cause (Final disease or condition reading to mineralize (auto property of the past 12 months) The past 12 months of the past 12 months of	() () ()			23a. Part I. Enter the disease, or com	plications that caused t	he death. Do	not enter the mode of dyi	ng, such as cardia	ac or respiratory	arrest,	IAIK, MD.	Approxima	te
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The finding with the set of the s		Examiner	L.	Sequentially list conditions,								2:4	en/s
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FEMALE: 20. Was decedent pregnant	876	ate be	Jical		d								
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State Registrar DHMH 17 Rev 1/2001 Described and place and deficiency of completed cause of death (Text 2001) Described (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 Described (Month, Day, Year)	ord	requir een s nould						<u></u>	1	Yes	ZE[No 3∐ F	Probably 4 ∐	Unknown
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	16 to 16	16	Decedent's Name (First, Middle, Last	st)		207111100	210 07 1	J04177	2. Date of De		0 1	3. Time of Death
	Physici		LOIS &	BOLDE	· N				Month 3	Day	Year 2007	5.45 AN
	/Medic		4a. Facility Name (If not institution, give			4b. Ci	ty, Town, or	Location of Deal			nty of Death	1
		ž6	Future Care Sandt	own			Balt	imore				
of.	Funeral		Social Security Number 6. Security Number		e (In yrs. last birth	day) If Und Month	der 1 Year	If Under 24 Hrs Hours Min		rth	9. Birth	place (State or Foreign
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pue	3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location						10d. Inside City Limits
Asici	유를	ក	MD		Balti							1√2 Yes 2 No
the A	28a-	ect	10e. Street and Number		Daics		Zip Code		I	10g. Citizen o	of Milhart Cour	
Ę	23a or 28a-f show	Ö	1811 E. Baltimore	Stroot		101.		1231				intry :
72 hours after death with the Marviand	The 2	Funeral Director	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was De			Specify Yes or No	US 14. R	A. ace - Ameri	ican Indian,
ler e	r freme	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 N				n, Mexican, Puer	Specify Yes or No to Rican, etc.)		lack, White,	
Sind	"natural", or iteme	þ	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 X No	Specify:		Spec	eify: bla	ack
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should	Mental narked c	2	John Devode						Grant			
202	7 te		19a. Informant's Name/Relationship (7 Amona Marshall/g						ural Route Numb reet Bal			p Code) 21231
s la	エラモ		20a. Method of Disposition		20b. Place of D	isposition (A	lame of	al I	Date	20c. Location	n - City or T	own, Stete
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permit Pages 1 ar			21. Signature of neral services icentional discon-	7.1	ctor		a nd Andiai imore		rd 655 W 201	. Balt	imore	Street
			23a. Part1. Enter the disease or comp shock, or heart failure. List only	plications that caused	the death. Do not					rrest,		Approximate Interval Between
	nysician Medical xaminer e priiai-transit	i Examiner	fmmediate Câuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underklying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or as a	a consequence of) a consequence of)	:) lier	Cell lun	ig Cs	nce-		Onset and Death
		dicai	•	d			-				-	
death cen	ed by the attending phy detached for use as th	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome of the first outcome of the first outcome of the first outcome of the first outcome of the first outcome	2 Fetaf death	3 □Ectopic 5 □ Other (Date of deliver	ery Day Year
	igned b be deta		Part fl. Other significant conditions co	ontributing to death bu	ut not resulting in th	ne underlying	g cause give	n in Part I.				he cause of death?
redn	been si	Completed by	Sepsis							Yes 2 □ No	3 Prot	bably 4 Durknown
sician: The law requires t	has b	npie	An se mi						24a. Was auto	osv	prior to co	opsy findings available impletion of cause of
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cian	is certificate director, pag	Be	25. Was case referred to medical examiner?	I I a - ma-1.					ath (Check only o	опе)		
or Attending Physician:	S 6	2		Hospital: 1 Inpatie				4 Nursing F	dome 5 Resi			fy)
Bull	After	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tirr ' <i>Ye</i> a <i>r)</i> Inju	iry	28c. Injury Work		28d. Describe	how injury occ	urred	
or Attending	ifter death Director: in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		iry - At home, farm (Specify)	M s, street, factor		∕es 2 □ No	28f. Location (City or To	Street and Num wn, State)	mber or Rura	al Route Number,
Hoepital	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Co	29a. Certifier 1 Certifying Phyone (Check only one) 2 Medical Exem	ysician: To the best of iner: On the basis of and manner sta	examination and/o	death occurre or investigation	ed at the timon, in my op	e, date and place inion, death occu	a, and due to the urred at the time,	cause(s) and r date and place	manner as s	stated. o the cause(s)
o the	o the	Me	29b. Signature and title of certifier			2	9c. License	number		29d. Date sign	ned (Month	Dev. Year)
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			30. Name and address of person who		ath (ftem 22a) (T		J 00 (01436	1	03	08	0/
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	Dhysia	ion	1. Decedent's Name (First, Middle,					Dete of Death Month	Day Ye	3. Time of Death
	Physic /Medi		JOEL		TWA			MARCH	06,2	207 1250 PM
	Exami	ner	4a Facility Name (If not institution,		1.201		4b. City, Town, or Loc SANDY	_	4c. County of D	
1			BROOKE GROVE RE 5. Social Security Number		e (In yrs. last bir		-			Ritholace (State or Foreign
ì	Funeral Director		150-20-4049 Usual Residence of Decedent	1∑M 2□ F		Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Nov 29,	1926 N	Birthplace (State or Foreign Country) ew Jersey
	and and		10a. State 10b. County		10c. City, Towr	or Location				10d. Inside City Limits
	Mary -f sh	ţ	MD Montg	omery	5	Sandy Spring	3			1 ☐ Yes 2√√√ No
	r 28a	<u>se</u>	10e. Street and Number	,		10f. Zip Code		10g.	Citizen of What	: Country?
	th with	a	18131 Slade Sc	hool Road			20860		USA	
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic event, the Medical Examenat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1d 1XYes 2 N If Yes, Give Year or Dates:	10	13. Was Decedent of Hif Yes, specify Cub 1 ☐ Yes 2 🏋 No	Hispanic Origin? (Spec an, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)		omerican Indian, White, etc. White
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9	Pages nent of It nt: If Ite		1 ☐ Burial 2 ☐ Cremation 3 4 🖾 Donation 5 ☐ Other (Spe		cemeter	y, crematory or other pla	ce/			
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other ti pnce.		21. Signature of Funeral Service Li		ector	22. Nama and Addre	ess of Facility Comy Board	655 W. E	Baltimor	e Street
			/mm/	Marc	aller de alle De a	Baltimore,	<u></u>			Anneximate
	D		23a. Part . Enter the disease, or c shock or heart failure. List o	nly one cause on each lin	the death. Do n	iot enter the mode of dyn	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
3	Physician /Medical		Immediate Cause (Final	A						0.1-1.11-7/
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Ő,	cate be executed physician and s the burial-transit	ũ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	FRONT	DIEMP	ORAL CEV	REBROUP	+SCULA	R	SIX WEEKS
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Division of Vital Records,	I or Attendir after death. Diractor: Al d in by the fu	Certification:	4 ☐ Homicide determin		iry - At nome, tai :. (Specify)	rm, street, factory, office	20	City or Town, S		r Aurai Aoute Mulliper,
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	ithin 2 the	Med	one) 29b. Signature and title of certifier	and manner sta	IOU.	29c. Licens	se number	29d.	Date signed (M	onth, Day, Year)
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•		-	30 Name and address of person w	ho completed cause of de	eath (Item 23a) (Type, Print)	, - , -	MA	vicet o	000/
			GRALE BROOKE 1-	WIFFMAN, A	J-D- 18	100 SLADES	icitooi Roa	o SANOUS	SPRING	MARYLAND
	St <i>a</i> Registr	ite	29b. Signature and title of certifier 30. Name and address of person w CLACE B. LOCKE 1- 31. Date filed (Month, Day, Year) MAR 1 6	Registra 2007	r's Signature	Sparke				
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Physician/ 3 Time of Death Month **Medical Examiner** ANTHONY ANDRE BRYAN 1540 hrs March 9, 2007 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore Ν/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral oreignMARYLAND Country) 220-80-4247 Months Days Director 07/28/1969 1X M 2 F 37 Yrs Usual Residence of Decedent 10a. State 'n 10b. County 10c. City, Town or Location 10d. Inside City Limits N/ABALTIMORE CITY MD 1 X Yes 2 No with the Maryland Directo 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21216 USA 1006 N. ELLAMONT STREET noti Funeral 11. Marital Status 12. Was Decedent Ever in U S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, death v Armed Forces? White, etc. 1 Never Married 2 Married Yes 2 X No ç should be filed within 72 hours after Divorced f Yes, Give Year 1 Yes 2 X No specify. Specify: BLACK ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) AMSEM METAL Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12 LABORER BUILDING CO. and Mental Hygiene 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) WILLIE JOHN BRYAN ETHEL PARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S STACYE B. SPEIGHT/SISTER 6000 AMBERWOOD RD, BALTIMORE, MD 21206 of Health 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 Removal from State 3/16/07 LANSDOWNE, MD ZION CEM. Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE, BALTIMORE, th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** only one cause on each line Mindreal a. Gunshot Wound of Head diate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran: Physician/Medical UNPENDED ysician burial -AMENDED Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy g phy 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Day Year Month use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autonsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical of Vital Be examiner' Other₄ Hospital: 1 / Inpatient 2 ER/Outpatient 3 DOA Nursing Hame 5 Residence 6 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) Mar 9, 2007 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Subject shot 0856 hrs Natural Division Yes 2 V No 5 Pending death the 2 Accident Investigation by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number City 3 6 Could not be Suicide or Town, State) 3001 Rosedale Court, Baltimore, MD determined (Specify) Local Street 4 Momicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 12, 2007 O.C.M.E Name and eddress of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

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Registrar

MAR 1 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** BER BARBER 755 2007 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore NSGXRELA OIN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Month 197 1951 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1₽M 2□F Months Days Hours MD 56-9034 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County or than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Baltimore Baltimore City Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 USA 2725 Winchester St. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or flems 23a any injury or other traumatic event, the Medical Exempted ONCE. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) № Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify:Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) N/AElementary/Secondary (0-12) College (1-4or 5+) N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Barber Albert Gaines ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Trina Hall/Daughter 2126 Westbourne Dr. Creedmoor, NC 27522 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Mar 16 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2007 ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) anle **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malmutriter 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Thomicide within 24 hours after To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier elal

Registrar

DHMH 17 Rev 1/2001

State

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

ANIL UBEOUC 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrer	State of Ma	ryland	-			lealth a Death			giene Reg. No.	007	i.	826	0
			Decedent's Name (First, Middle, Las	t)							2. Date of Dea		Ye	25	3. Time of Dea	.th
	Physici /Medic		Basil Bignes	,							March) ~		07	GB	LM
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City.	Town, or	r Location of	of Death		4c.	County of D	Death	1	
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н	Funeral		5. Social Security Number 6. Se	ex 7.Agn6 DŽM 2□F	(In yrs. last	Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da 8 / 22 /	n Y. Year) I Q 1 2	9. M	Count	ice (State or Foi y) LAND	·eign
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	i within 72 hours after death with the Maryland liene. r then "naturel", or Items 23e or 28e-f show the Medical Evarinar must be notified at	Funeral Director	2907 WILLOUGHE	Y ROAD			21	234					USA			
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	and 2 aalth a n 27 ls		RICHARD BIANCON	II / SON					RLES	STF	REET UN	1IT	4 BA	$_{ m LTO}$. MD.	
Baltimore,	- F 5 F		20a. Method of Disposition	Damarat from State	20b. Plac	e of Dispo	natory or	me of other plac	ce)		Date	20c. Lo	cation - City	or Tov	n, State	
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alti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licen	see ()"		22	2. Name a	nd Addre	ss of Facili	yCVA	CH/ROS	SEDA	LE F	UNE	RAL HO	ME
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			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused one cause on each lin	the death. e.	Do not ent	er the mo	de of dyin	ng, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between	
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	/Medical		resulting in death)	Due to (or as a	consequer	nce of):										
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Вох	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1⊡Live birth : 4⊡Pregnant at	2 ☐ Fetal de	eath 3[□Ectopic p □ Other <i>(s</i>		y 				Month		Day Year	
o.	at the de by the a tached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown			,	, ,,								
a	de ed		Part II. Other significent conditions of	ontributing to death bu	t not resulti	ng in the u	nderlying	cause giv	en in Part I		23e. Did t	obacco u	ise contribu	te to the	cause of death	1?
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	14		30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type,	Print)	5 7	,	0.3	Town	04	mil		21201	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 13, 2007 March 3:35p Alma M. Bauer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Riverview Nursing Center Baltimore Essex 8. Date of Birth (Month, Day, Yeer) Jan 16,1911 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🕡 F 96 Yrs. 217-01-0603 Director PA Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits rthen "netural", or itema 23a or 28a-f ehow the Medical Examinar must be notified at MD Baltimore 1 ☐ Yes 2 ☐XNo Essex Direct 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1000 Franklin Avenue 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after al Hygiene. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Lord Baltimore Press Elementary/Secondary (0-12) College (1-4or 5+) Inspector 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 le marked otf Fredrick Deshner Cora McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rayna Thormann / niece 15 Francis Green Circle Balto.MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/16/07 permit. Page Department o Important: If eny injury or once. OAk Lawn Cemetery Baltimore MD 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Juderal Service Licensee Connelly Funeral Home of Essex 23a. Part. Enter the disease optimplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ereprovadular year **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes 2 No or Attending Physicien; Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar

31. Date filed (Month, Day, Year) MAR 1 6 2007

John

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month **Physician** 8:30 A M March Eunice Church Barker 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8455 Murphy Road Laurel Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 9 1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🗓 F 96 Hours North Carolina 239-07-3042 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Eximiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8455 Murphy Road 20703 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. ģ Specify: White 3 Nidowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker owned home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Pink Church Sarah N Church 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Sessler, Friend 12363 Pleasant View Drive Fulton MD 20759 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodland Cemetery 4 ☐ Donation /5 ☐ Other (Specify) Winston-Salem, North Carolina 3/15/2007 21. Si x ature IF neral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Rd Laurel MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Dementia years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: nse If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death Month Day Year 5 Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2X No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specify) group home 1 ☐ Yes 2 💢 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation ours after death.

neral Director; A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide /within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51860 3/15/2007

State Registrar 31. Date filed (Month, Day, Year)
MAR 1 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Jonathan Fish MD 10700 Charter Drive Suite 200 Columbia MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		rtment of H		, ,	iene	7 08263
	Physici		1. Decedent's Name (First, Middle, Last	0				2. Date of Death Month	Day Ye	3. Time of Death
	/Medio Examir			Street		Annap	Location of Deat		4c. County of E	Inndel
	Funeral Director		5. Social Security Number 6. Se 217-24-5952 9 Usual Residence of Decedent	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, May 30,	Year) 9. 1930 A	Birthplace (State or Foreign Country) ARY AND
	e Maryland a-f show	ctor	10a. State 10b. County MD ANNE	4	Town or Loca	ation APOLIS	5			10d. Inside City Limits 12 Yes 2 □ No
36	within 72 hours after death with the Maryland ene. than 'natural', or items 23a or 28a-f ehow ha Madisal Examinar musi Es notified al	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give		as Decedent of H Yes, specify Cuba		specify Yes or No- to Rican, etc.)	Black, V	t Country? STATES American Indian, White, etc. BLACK
21215-0036	i within 72 hours jiene. r then "natural", ine Medical Ex-	Completed b	3 ☐ Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give ki life. Di		during most of wo	rking	16b. Kind of Busine	ess/Industry
	万高を研	Be	17. Father's Name (First, Middle, Last)	VOOD BROWN	MAIN	TENAN	18. Mother's Nar	PAIR THE (First, Middle, M	Maiden Sumame)	ALGOV'T
ore, Maryland	Pages 1 and 2 should be filed tent of Health and Mental Hyg int: if item 27 is marked othe iry or other traumatic event,	To	19a. Informant's Name/Relationship (7) 20a. Method of Disposition 1 Repural 2 □ Cremation 3 □ 1	ype, Print) C \(20b. Place and the common of the c	790 pe of Disposi	Address (Street a S DAR tion (Name of atory or other place	And Number or Ru	Plate Number,	City or Town, State EN BUR 20c. Location - City	or Town, State
Baltimore	permit. Pag Department important: sny injury once.		4 Donation 5 Other (Specify, 21. Synature of Fune al Service Licens	H	LLCK 22. Mi	REST Name and Address NATER'S A	0,000	/		FREST DR.
	Physician /Medical		23a. Part 1. Enter the disease of comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequer	4 00	the mode of dyin	g, such as cardiae	or respiratory arre	est,	Approximate Interval Between Onset and Death
760, Ey	te be executed ysician and burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)						
. Box 68	death certifica e attending ph d for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3 □E	ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	The law requires that the de ste has been signed by the a page 2 should be detached	þ	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the und	derlying cause give	en in Part I.			te to the cause of death? Probably 4 Unknown
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		3□ DOA Othe	A.F.	ath Check only one	•	
ion of	To the Hospital or Attending Physician: Within 24 hours after dead. To the Funeral Director After this certific completely filled in by the funeral director.	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 EH	8b. Time of Injury	28c. Injun Work	4 Nursing F	dome 5 Reside 28d. Describe ho		Specify)
Divis	ital or Atters after dear al Directored in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (Str City or Town	reet and Number o , State)	r Rural Route Number,
	Hospital 24 hours a Funeral letely filled	Medicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	rsician: To the best of my knowle iner: On the basis of examination and manner stated.						
)	To the within 2 To the comple	Me	29b. Signature and title of certifier	- Rhee MD		29c. License	o number 06437	29 PANNS	3/13/0	lonth, Day, Year)
	1		30. Name and address of person who c	ompleted cause of death (Item 23) The Rhee 90	3a) (Type, Pi	rint) Take R	d Sute 3	100 Anna	polo MI)	2401
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6	32. Registrar's Signature	o As	and a			-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryland / Department of Health and M State Registrer Certificate of Death	lental Hygie	201	7	08264
		8,		Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Yeer	3. Time of Death
		Physici /Medic		Wilhelm J. Brzuchalski	March	7, 20		2:00 P M
		Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County o	f Death	
				Keswick Nursing Home Baltimore				
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 12 76 0076 12 M 2 F 90 Yrs. Nonths Days Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 9,	a() 2.7	9. Birthp Cour	place (State or Foreign http:// Maryland
		Director		212-76-0976 123 M 2 80 Yrs.	reb. 9,	1941		Haryrand
		/land		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
		ier death with the Marylan iteme 23a or 28a-f ehow net must be notified at	tor	Marylane Baltimore Baltimore				1 ☐ Yes 2 No
		or 28	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of W	nat Cour	ntry?
		23a c	aic	930 Kinwat Avenue 21221		U.	S. A	
		r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	acify Yes or No- Rican, etc.)		 Amenia White, 	ean Indian, etc.
	36	s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No		Specify:	r.rh. 4	1+0
	8	turei terei	ed to	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	161	b. Kind of Bus	Whi	
5	5	in 72 ho n "natur	ojet	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	ing	D. KING OF BUS	110334111	dostry
0	212	y withir	Completed	Elementary/Secondary (0-12) College (1-4or 5+) None Never Worked				
8	Þ	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or iteme 23a or 28e-f ehow other than "natural", or iteme 23a or 28e-f ehow event, the Medical Examinat must be notified at	Bec		(First, Middle, Ma)	
A:00PM	/lai	should be and Mental marked o	To	Adam M. Brzuchalski Eliza	abeth Hal	uch		
4	Maryland 21215-0036	e de la composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della comp	8 8	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		-		
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Ĺ	ore	Jes 1 I of H		1 X Burial 2 Cremation 3 Removal from State		c. Location - 0	•	
0	Ë	Pa(tmen) tant: jury		4 Donation 5 Other (Specify) Holy Cross Cemetery 03/12				
70/1/8	Baltimore,	permit. Pages 1 Department of H important: If ite eny injury or ot once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schrift 3331 Brehms Lane, I				
		Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Approximate Interval Between Onset and Death
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Wilhe	O. Box	Attending Physicien: The law requires that the death certificate be executed rideath. •ctor: After this certificete has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 1 Compared to the pregnant at time of death 9 Unknown 9 Un		23d. Date Mon		ery Day Year
3	٦	that the	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contri	oute to t	he cause of death?
_	rds	quires n sign ald be	Completed by	HYPERTEUSION	1 🗆 Yes	2 🗆 No	3 🗌 Prob	pably 4 Unknown
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工	0	ding Physician:			28d. Describe how			
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7	Divisio	al or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Numbe State)	r or Rura	al Route Number,
36		To the Hospital or Atti within 24 hours efter de To the Funerel Direct completely filled in by th	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the caus ed at the time, date	se(s) and man and place, a	ner as s	tated. the cause(s)
(mm/		To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed	(Month.	Day, Year)
				Dendall Rhallly D25643	3	191	07	
	-			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		/ /		
		Ψ		Kendall Faulkner, 700 W. 40th St., Baltimore, Maryano	1 21211			
		Sta	ite	31. Date filed (Worth, Day, Year) 32. Registrar's Signature				-

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** 6:55 Alexander Kirkland Barton 2007 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Blakehurst Life Care Community If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** ountry) California 1**X**M 2□F February 14,1923 84 212-20-3617 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Baltimore Towson Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 United States 1055 W. Joppa Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No if Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify: Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) insurance broker insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaretta Ankarcrona Alexander Kirkland Barton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, MD 21204 Cary Lee Barton/wife 1055 W. Joppa Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory Mar. 13,2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, 21. Signature of Funeral Service License Inc. John O. Mitchell 6500 York Rd. Baltimore, MD 21212 Approximate Interval Between Onset and Death 23a. Jart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final MATE Physician months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter the same (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 🐧 No 3 ☐ Probabiy 4 ☐ Unknown been si should I Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 2 No s certificate has b lirector, page 2 s death? 1 ☐ Yes 2 □ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28d. Describe how injury occurred Certification:

certificate be executed Box 68760, Division or Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

within 72 hours after death with

Baltimore, Maryland 21215-0036

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

Medical

State Registrar 4 Homicide

28b. Time of 28a. Date of Injury Injury 5 ☐ Pending investigation

(Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month. Dav. Year)

31. Date filed (Month, Day, Year)

32 Degistrar's Signature

W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles ST Baltimore un 21204

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician HILDA BLANS 0853 MARCH 13 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE I+USPITAL PANDALLSTOWN NORTHWEST If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Director 93 06/25/1913 160-01-9007 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show BALTIMORE 1 ☐ Yes 2 X No rral", or items 23a or 28a-f st Examiner must be notified Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 725 MT. WILSON LANE APT. #333 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural" or Item 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE ģ 3 X Widowed 4 ☐ Divorced If item 27 is marked other than "natural", or other traumatic event, the Medical Exa Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be HYMAN MILLER **JENNY** GREEN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RANDALLSTOWN, MD 21133 Date 20c. Location - City or Town, State SHEILA BONNELL / DAUGHTER 4042 CARTHAGE ROAD -20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK:03/14/2007 | RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mall 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Magnitato /Medical Due to (or as a consequence 4): Examiner Symration Sequentially list conditions, if any, leading to immediate cause. Enter or can, if Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ⊠Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2★ No 24a Was an autopsy 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To this spital or Attending Phours after death. neral Director: After th 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D Hospital 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

31. Date filed (Month, Day, Year) State MAR 1 6 2007 Registrar

29b. Signature and title of certifier

DEBORAH

FITZPATEICK 32 Pegistrar's Signature

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Retork

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTHWEST

29c. License numbe

D0059736

HOS PITAL

29d. Date signed (Month, Day, Year)

5401 040

13, 2007

COURT RUAD

Registrar

State

FREDERICK MD

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

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Year

ate filed (Month, Day,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date Month 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** $\rho_{\rm M}$ 1213 ulius (onwal 07 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Columba Howard County General Hospital Howard Social Security Number 106-24-8300 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**2**M 2□F Days Hours Min. 06/22 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2 No -olumbia Be Completed by Funeral Director Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ant; If Item 27 is marked other than "natural", or items 23a or items or other traumatic event, the Medical Examiner must be not or the traumatic event. 21040 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Blac 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16bcKind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (Firet, Middle, Last) Buo Ker anway 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) Columbia, MD 21042 Conwa 20a. Method of Disposition Burial_ 2 Cremation 3 Removal from State Department of Important; If any injury or once. olumbia, MD 5 Other (Specify) 4 □ Domation 21. Signature of Furer Service Licens le funeral Services Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. PRoba Immediate Cause (Final disease or condition resulting in death) **Physician** therosclera /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed redemio physician and s the burial-trans perli Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical nd manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

AMBRA

31. Date filed (Month, Day, Year)

MAR 1 6 2007

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100 W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AZ. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death lent's Namel (First, Middle, Last) 3. Time of Death **Physician** 2007 10:30YM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not titution, give street and number) 4c. County of Death Examiner tosoïce timore 7. Age (In yrs. last birthday) If Under Under 24 Hrs. 8. Date of Birth (Month, Day, 09-24 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 10**X**M 2□F 5 Yrs. Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at MD 1 Yes 2 □ No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? edmon8on 21228 +00 nue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Secondary (0-12) College (1-4or 5+) nanic ather's Name (First, Middle, Last) 18. Moth, r's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be to Dep unment of Health and Mental them 27 is many nury or other 27 is many nury or other. 100 k Wries Informant's Name/Relationship (Type (Street and Number N Rural Route Number dmonson I(U)40 20b. Place of Disposition (Name of cemetary, crematory) or other Date Wethod of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 0 4 ☐ Dopation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee Cility June Nat Babbo, MD 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certiticate be executed led by the attending physicien and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗆 No 3 Probably 4 Dunknown 1 Yes 4b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1 Yes 2 12 No Be 25. Was case referred to edical 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 200 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specif 3□ DOA Atter this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Divatural Injury 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: tilled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide emined within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29d. Date sigged (Month, Pay, Year) 29c. License number

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

7-01639		Please Type or Print in Black Indelible I	nk. Ensure All Copie	es Are Legible.	
largaret Carpe	r	State of Maryland / Department o	f Health and Mental H		07 0827
		1- For State Certificate O	f Death	Reg. No.	0 1 1,00.7
Physici Medical Exam				Date of Death Month Day Year	3. Time of Death
geuicai Exam	mer	nargaree ourper	4b. City, Town, or Location of Death	Month Day Year February 26, 2007	2345 hrs
		Harbor Hospital Center	Baltimore	h 4c. County of D	eatn
Funeral		5. Social Security Number 1 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	s. 8. Date of Birth(MM/DD/YYYY) 9	. Birthplace (State on unk
Director		1_M 2XF 51 Yrs	Months Days Hours Min		oreign Country)
		Usual Residence of Decedent		July 20, 1933	
any		10a. State 10b. County 10c. City, Town or Local	ion	-	10d Inside City Limits
Maryland 28a-f show d at once	ō	MD Brookly	'n		1 X Yes 2 No
Maryl. 28a-f dato	Director	10e. Street and Number	10f. Zrp Code	10g Citizen of What	Country?
ith the Maryland 23a or 28a-f sho notified at once			21225	USA	
th wit ems 2 t be n	Funeral	11. Marital Status UNK 12. Was Decedent Ever in U.S. 13. Was 1 Never Married 2 Married Armed Forces? Y. 13. Was 15. Wa	is Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No- DiRican, etc.) 14. Race - A White, et	merican Indian, Black,
er death , or ite	Fur	1 Yes 2 No			
2 hours after "natural", I Examiner	by	3 Widowed 4 Divorced It Yes, Give Year 1 1 15. Decedent's Education (Specify only highest grade completed) 16a Deceder	Yes 2X No specify:	Specify: work doneunk 16b. Kind of Busine	white ess/Industry unk
2 hou "nat	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use reti		dik
5-0036 Led within 72 Hygiene. other than '	nple	unk unk			
15-003 Ted withi Hygiene.	Co	17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	e (First, Middle, Maiden Surname)	unk
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be				_
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	7			Rural Route Number, City or Town, S	state, Zip Code)
nore, MD 21214 ages I and 2 should be fil nt of Health and Mental I tt: If item 27 is marked other traumatic event, I			Penn Street Balt	Date 20c Location - Cit	or Town State
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traum		1 Burial 2 Cremation 3 Removal from State crematory or of		Date 200. Eddation - Cit	y or Town, State
timor t. Pages tment of rtant: If		4 Donation 5 X Other Specify: in state			
Balti permit Departm Importa			-	d 655 W. Baltimon	re Street
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter t	Itimore, MD 2120 he mode of dying, such as cardiac of	0 1 or respiratory arrest, shock, or heart	Approximate Interval
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic intoxication			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Narcotic intoxication Due to (or as a consequence of):			
	_	Sequentially list conditions, b			
	in	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Examiner	events resulting in death) Last Due to (or as a consequence of):			
ecuted and transit	alE	<u>a.</u>			
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Box 68760, steath certificate be exthe attending physician edfor use as the burial.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe		23d. Date of del	very Day Year
x 68 h certi endin use as	cial	past 12 months? 2 Fe	tal death 3Ectopic pregna her (Specify)	aricy World's	Day Teal
Bo; e deatl the att	hysi	1 Yes 2 No 9 V Unknown 9 Unknown			
	by P		ınderlying cause given in Part I.	23e. Did tobacco use contribut	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	o pe				Probably 4 V Unknown
ord: w requisitions	plet			autopsy prior	e autopsy findings available to completion of cause of
Recc The lavicate ha	Completed			performed? deat	h? Yes 2 No
Vital Reo ysician: The his certificate director, page	Be C	25. Was case referred to medical	26 Place of Death (Check	only one)	
'hysic r this	힏	1 Yes 2 No Rospital 1 Inpatient 2 ER/Outpatient		· · ·	ither:
n of ding Ph After funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)		28d. Describe how injury occurred	
Sior Attend death ector: by the	cati	Pending Investigation Fnd 2/25/2007 unk	1 Yes 2 X No	unk 28f. Location (Street and Number o	Pural Pouta Number City
Divis pital or At ours after d teral Direct	Certification:	3 Suicide 6 X Could not be determined (Specify) house	et, factory, office building, etc.	603 Holy Cross Rd. I	
lospit 1 hour unera		/9a Lentiler	red at the time date and place, and		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) Check only one) Certifying Physician. To the best of thy knowledge, dearn occur one) Wedical Examiner: On the basis of examination and/or investiga			
To with	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
		(luax)	O.C.M.E.	March 2, 2007	7
		30. Name and address of person who completed cause of death (Item 23a)			-
			Street, Baltimore, MD 2120	1	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis	trar	MAR 1 6 2007 Allegar Al Armal	<u></u>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2007 B:04 AM ^M Clarence E. Carter March 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 231-30-0191 Director 79 May 28, 1927 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at Director 1 ☐Yes 2√No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen ol What Country? 909 D Royal Street 23a 21401 Pages 1 and 2 should be filed within 72 hours after death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: Specify: black þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 Is any Injury or other trau once. Anne Arundel Medical Center 2001 Medical Parkway Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 \$ Other (Specify) in state S. Warde, Director 21. Signature of Funeral Services Rona L State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 22222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) **Physician** Pheumonia weeks /Medical Due to (or as a consequence of): Examiner Neck Cana Head and eaus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this After thi funeral 27. Manner of Death 1 Aatural 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01852 Z MARCH 2007 Name and address of person who completed cause of death (Item 23a) (Type, Print) DE VORE MD 4203 QUEENSburg Rd Hyattsi, He MD20187 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DOLORES COATES FEB. 2007 5:11P 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2√2 F 78 02/23/1929 MARYLAND 10d. Inside City Limits

/Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 14 N. MORLEY STREET 5. Social Security Number **Funeral** 217-26-0882 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location BALTIMORE CITY r 28a-f sh notified MD N/ADirector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö be USA 14 N. MORLEY STREET 21229 ms 23a Funeral r than "natural", or items the Marical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 □ **ty**to ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COOK 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event Be ELIZABETH TRUSTY WEBSTER THOMAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, P. 2701 W. BALTIMORE ST., BALTIMORE, 19a. Informant's Name/Relationship (Type. Print) MELVIN GREEN/ PERSONAL REP. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 3/17/07 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 Funeral Service Licens Enter the disease, or complications that caused thook, or heart failure. List only one cause of each life death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Im redio e Cause (Final dis as e or condition rest ting in death) **Physician** LA /Medical a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed ig physician and as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☑ No 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 24a. Was an cate has 1∐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 5 ☐ Pending jrtvestigation (Month, Day Year) Injury 1 □ Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director; A
filled in by the fu 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3□ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier

30 Name and address promon who completed cause of death (Item 23a) (Type, Print)

31. Date filed Month, Day, Year)

32. Registrar's Signature

MD 2122B 20c. Location - City or Town, State BALTIMORE, MD 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Approximate Interval Between Onset and Death 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

1 Yes 2 No

Race - American Indian.

BLACK

Black, White, etc.

FOOD SERVICE

Specify:

Physician

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:05 A.M JANE KENNEDY COMBER March 13, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Stella Maris Hospice Timonium

If Under 1 Year | If Under 24 Hrs. | Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 👿 F 216-24-7479 78 Maryland Director April 14, 1928 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County la or 28a-f show t be notified at 1 ☐ Yes 2 X No Director Baltimore Maryland Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. S-607 2525 Pot Spring Road 21093 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Heath and Mental Hyglene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Edward Kennedy Catherine Drechsler Marie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type. Print) Thomas F. Comber, 3rd. (Husband) 2525 Pot Spring Road Apt. S-607 Timonium, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) St. Mary of the Assumption Ch. Cem. 3-17+07 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212

Approximate A 21. Signature of Funeral Service Licensee Secret Fernance | Mitchell-Wiedefeld Funeral 1 6500 York Road Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BREAST CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last g physician and as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

Division or Vital Records, P.O. Box 68760,

(0 State Registrar

one).

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year)

MAR 1 6 2007

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician
/Medical
Examiner

Funeral

Director

death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at filed within 72 hours after Hygiene. permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event *ha-

Saltimore, Maryland 21215-0036

Physician /Medical **Examiner**

as the burial-tran signed by the attending physician and be detached for use as the burial-tran spital or Attending Physician: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, pa

Division or Vital Records, P.O. Box 68760.

To the Hospital o within 24 hours aff To the Funeral D Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Margaret Lorraine Dodson 01:40 A M February 2007 28, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M Vrs 224-34-8610 75 May 19, 1931 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County XX Yes 2 □ No Maryland Annearunde1 Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 160 Konred Morgan Way 20711 USA Funeral . Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: White <u>ک</u> 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zollie J. Kuser Charlotte Fleming ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie Lambert - Daughter 160 Konred Morgan Way Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 03/03/07 Panorama Memorial Gardens 4 □ Donation 5 □ Other (Specify) Waterlick, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Turner-Robertshaw Funeral Home 1200 N. Shenandoah Ave. Front Royal 22630 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or licent failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK Due to (or as a consequence of): INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Donknown Completed FRACTURE-OSTEOPOROSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D58900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julia L. Surratt 100 Hespital Rd. Prince Frederick MD 20678 State

Approximate Interval Between Onset and Death 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 1□ res 2□ No 3□ Probably 4□Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2007

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐Yes 2 No

8:45 PM^M

29d. Date signed (Month, Day, Year)

Reg. No.

4c. County of Death

USA

Specify:

16b. Kind of Business/Industry

communications

Month

Baltimore

Virginia

14 Bace - American Indian

white

Black, White, etc.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZrazMirzamo,

32. Registrar's Signature

1963

lowson,

State Registrar 31. Date filed (Month, Day, Year)

MAR 1 6 2007

regreat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - For Amend #4c H	State of Marylan er PHY G765	d/2020 2020	artmei Th rtifica	nt of Heate te of De	alth and M eath	Mental Hy	giene () (Reg. No.)7	08276
	Dhusisi		1. Decedent's Name (First, Middle, Last)						2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medic		Roy Jack Franta	ì					March 1	13, 2007		23:20 M
	Examin	er	4a. Facility Name (If not institution, give					cation of Death		4 Harr		_
			Harford Memorial 5. Social Security Number 6. Secu		last high days		r 1 Year II	Grace f Under 24 Hrs.	9 Date of Bir	Havre		
	Funeral Director		510-26-6435	M 2□F 79	Yrs.	Months		Hours Min.	8. Date of Bir (Month, Da Dec • 1	4, 1927	Kan	place (State or Foreign ntry) Sas
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
	Mary Lind	tor	Maryland Harford	Нэгл	re de (Trace	.					1 ☐ Yes 2 📉 No
	h the	Director	10e. Street and Number	TICVI	<u> </u>		p Code			10g. Citizen of	What Cou	ntry?
	23a c	ai D	108 Concove Way				21078			USA		
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show says injury or other traumatic event. Its Medical Evant and must be notified at ADGS.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	 12. Was Decedent Ever in U. Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Year or Dates: 		Was Dece If Yes, spe 1 ☐ Yes	ecify Cuban, I	anic Origin? (S) Mexican, Puerti Specify:	pecify Yes or No Rican, etc.)		ck, White,	can Indian, etc. ite
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ž	hould d Mei mark matic	ဥ	Michael (unk) I 19a. Informant's Name/Relationship (Ty	ranta	10h Maili	na Addres	s (Street and	Mary Number of Bu	(unk)	DVOĽK per, City or Town,	State Zir	Code)
Σ	od 2 s Ith an 27 ie traui		Monica Franta / V			-				ace, MD		
	f Heal		20a. Method of Disposition	20b. P	Place of Dispo	sition (Na	me of		Date	20c. Location		
E O	Page: ent of nt: if ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	. Erin			Cem 3-1	16-07	Havre d	le Gra	ace, MD
Baltimore,	permit. Departm Importa eny inju		21. Signature of Funeral Service Licens	nd, ed a	22				Home, P			
			23a. Part 1. Enter the disease, or compl	cations that caused the deat	h. Do not ent	1317	Cokes	sbury Ro	or respiratory a	ingdon, _{urrest}	MD_{2}	Approximate
п	Dharatatan		snock, or near tallure. List only of	ne cause on each line.					.,,			Interval Between Onset and Death
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68760,	ficate be executed physician and s the burial-transit	dicai		1.							-	
P.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degree of the second 1 □ Unknown	I death 3	⊒Ectopic ⊒ Other (s	oregnancy pecify)			1	te of deliventh	ery Day Year
σ.	res that igned by be deta	by Pr	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying	cause given	in Part I.	23e. Did	tobacco use con	tribute lo t	the cause of death?
rds	quires n sign	g pe	HYPONATREMIA	1, HYPERTER	USION	/			1 🗆	Yes 2 No	3 ☐ Prot	babły 4 □Unknown
Division of Vital Records,	e law require has been sig je 2 should b	Completed	HYPERUPIDEMI	/					24a. Was	DSV	Were auto prior to co death?	opsy findings available ompletion of cause of
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ion	nding ath. r: Afte e fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м		s 2 No				
Divis	or Atte after dea Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif		reet, facto	ry, office			(Street and Number, State)	ber or Run	al Route Number,
_	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2	Medical Co	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	wledge, deat	h occurre	d at the time, n, in my opini	date and place ion, death occu	, and due to the	cause(s) and m	anner as s	stated. to the cause(s)
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Δ	11		30. Name and address of person who co		n 23a) (Type		D453	79		03/14/	1200	7
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FRANTA,

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3/13/07

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and M	-	•	0070
			1 - State Registrar Certificate of Death	Reg.	No:	00417
	Physicia	20	1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Albert Frank Gentile	March	12 2007	8:15 p
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	2.00
			Greater Baltimore Medical Ctr. Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Oay, Ye	Baltimo	ore (State or Foreign
	Funeral Director		214-14-0996 1X M 2 F 84 Yrs. Months Days Hours Min.	3/31/192	ear) Count 2 Mary	vland
	ס		Usual Residence of Decedent			d, Inside City Limits
	arylar show	_	10a. State 10b. County 10c. City, Town or Location			1 ☐ Yes 2 🛣 No
	he M 28e-f	Director	Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code	100	. Citizen of What Count	
1	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Modical Exertinal terrollifical at					,
+	death ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp		S. A. 14. Race - America	
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ANDe 215-0036	"nate	lete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16	b. Kind of Business/Ind	ustry
212	withir ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 8 Truck Driver		Steel Mill	
_ d 2	filed Hygi other ant. I	Be Co		e (First, Middle, Ma		
	uld be Mental rked r	To B	Phillip Gentile Margare	t Sch	oenhoff	
File, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic avant. Ite Madical Exercit efficies to collect rediffied and once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number, C	City or Town, State, Zip	Code)
+ ≥	and 2 ealth n 27 i		Phyllis Jean Swezey (Daughter) 2008 Longview Avenue			
O se	jes 1 of Hi if itar		1 ABurial 2 Cremation 3 Removal from State cemetery, crematory or other place)	6	c. Location - City or Tov	vn, State
altimor	tment tant:		'4 Donation 5 Other (Specify) Sacred Heart of Jesus! 200	7 <u>D</u>	undalk, Mai	ryland
Ba	permit Depar Impor any Ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funera. 1407 Old Fastern A	l Home PA	Mola	
			23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dving, such as cardiac		sex, Maryla	Approximate Interval Between
	Di di		shock, or heart failure. List only one cause on each line.			Onset and Death
	Physician / /Medical		disease or condition resulting in death) a Endstage Renal Disease Due to (or as a consequence of):			4 weeks
	Examiner		Sequentially list conditions b. Clostridium Difficile			l week
	P =	ner	Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
Ni)	executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
,09	be	cai E)	Due to (or as a consequence of).			
687	physicate s the		d			V.
Вох (certif nding use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	ry
	death e atte	icia	in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.O.	at the by th	hys	9 Unknown			
s,	The law requires that the death certificate tte has been signed by the attending phys vage 2 should be detached for use as the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cca use contribute to th	.
ord	requii	Completed				/3
Sec	e law has b	nple		24a. Was an autopsy performe	24b. Were autop prior to con death?	sy findings available apletion of cause of
<u>a</u>	sician: The lav certificate has rector, page 2				No 1 ☐ Yes	2 □ No
Ĭ,	sicial certi	o Be	examiner? Char	th (Check only one)	ce 6 □Other (Specify)
of	g Phy er this		27. Manner of Ceath 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		,
ion	ath. r: Aft	atlo	2 Accident investigation M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town,	et and Number or Rural State)	Route Number,
	ital o urs aft rel Di	Cer				
	t Hosp 24 hou Fune stely fil	ledical	29a. Certifier Check only Addical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and tipe of certifier 29c. License number	290	I. Date signed (Month, L	Day, Year)
			D63830	М	arch 13,	2007
	841		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
			Jeffrey B. Brown, M.D., 6701 N. Charles St. Room 4809	, Towson,	_{MD} 21204	
	Sta Reģist		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 6 2007			
		16	WELL &			

				ertificate of Death	, 0	No.2 0 0 7	BB28(
	Physici /Medi		1. Decedent's Name (<i>First, Middle, L</i> ast) BARBARA	GILES	2. Date of Death Month MARCH	Day Year 11 2007	3. Time of Death 7:30 A M
	Examir		4a. Facility Name (If not institution, give street and number) The JoHNS HOPKINS HOSPITAL		ITY	4c. County of Death	
ě.	Funeral Director		5. Social Security Number 226 – 34 – 5716 6. Sex 1 □ M 2√√ F 7. Age (In yrs. last birthday 7. A	y If Under 1 Year If Under 24 Hrs Months Days Hours Min.		(ear) 9. Birthp Court 1932 VIR	place <i>(St</i> ate or Foreigi ntry) RGINIA
	e Maryland 3a-f show tiffed at	ctor	Usual Residence of Decedent 10a. State	ocation IMORE CITY		1	10d. Inside City Limits 1 X Yes 2 □ No
	th with th	Funeral Director	10e. Street and Number 110 N. CENTRAL AVENUE, #405	10f. Zip Code 21202	10g	. Citizen of What Cour	ntry?
036	be filed within 72 hours after death with the Maryland stal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2√√ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.
21215-0036	within 72 ho ene. than "natur ne Medical I	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	orking 16	ib. Kind of Business/In	·
nd Z	al Hygie I other i vent, th	Be Co	12TH 3 YEARS EV	ANGELIST 18. Mother's Na	me (First, Middle, Ma.	MINIST iden Surname)	'RY
<u>Y</u> aı	should be nd Mental marked c	To 1	FRANK CHAPPEL		CILLA EVA		
Ĕ	s 1 and 2 should f Health and Men tem 27 is marke other traumatic		TROY GILES / SON 649	ing Address (Street and Number or R BUESTMINSTER F	REACH, SM		4373
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, or MD VFTI	amatani ar other placel		oc. Location - City or To	•
Bal	permit. Pag Department Important: I any injury o	li 9	21. Signature of Funeral Service Licensee	22. Name and Address of Facility HC 4600 LIBERTY E	OWELL FUN HEIGHTS A	ERAL HOM	E 21207 IMORE, M
	Physician /Medical		23a. Rot1 fer the disease, or complications that caused the death. Do not en stock or head failure. List only one cause on each line. Imm rdiar Cause (Final disease) or condition resulting in death) Bowu Tscher Due to (or as a consequence of):		c or respiratory arrest	,	Approximate Interval Between Onset and Death
	Examiner	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Amyloido sis Due to (or as a consequence of):	-			3 months
>-	ecuted and -transit	Examiner	Cause (Disease or Injury that initiated events c				
8/60,	rtificate be executed ng physician and as the burial-transit	Aedical E	Due to (or as a consequence of):				
e Rox	death certif e attending ed for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
rds, P.	requires that the een signed by th nould be detache	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	he cause of death?
Lec	The la ate has page 2	Completed			24a. Was an autopsy performed	d? prior to coi	opsy findings available impletion of cause of
VItal	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	Other	ath (Check only one)		
ISION OF	ing Affel	- 1	27. Manner of Death 1 Natural 5 Pending 2 Accident 1 Nospital 1 Inpatient 2 ER/Outpatient 2 ER/	AL SU BOA 4 INUrsing F	dome 5 ☐ Residenc 28d. Describe how	e 6 ☐Other (Specifing injury occurred	<u>y)</u>
DIVIS	al or Attend after death. I Director: // d in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
:	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	ledical C	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or is and manner stated.	th occurred at the time, date and place envestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as si and place, and due to	tated. o the cause(s)
i	To the To the Comp.	Me	29b. Signature and title of certifier	29c. License number		. Date signed (Month,	
1			30. Name and address of person who completed cause of death (Item 23a) (Type	Kes - 000	MA	IRCH 11, 7	2007
	4		Kelly Schlendorf The Johns Hopking Ho	spital, 600 Northe Wo	1 Re Street. B	Saltimore MARYLAND	21287
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 2007 33 Registrar's Signature	who are	1		_

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Teri Lee Gebhardt 2007 March 18:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF 180-44-5738 Director 54 Aug. 13, 1952 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov idical Examiner πust be notified at 1 ☐ Yes 2 No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2301 Franklin Chance Ct. 21047 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed ortant: If item 27 is marked other than "natui injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Technologist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H ပ Carl Franklin Morrow Jr Blanche Arlene Mathiot 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau Fred C. Gebhardt / Husband 2301 Frankl<u>in Chance Ct., Fallston, MD 21047</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 3-9-07 Towson, Maryland 21. Signature of Syneral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastati Physician y-ear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiriei : 1 ☐ Yes 2 💢 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: mpletely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) MAR 1 6 2007

30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

Jason Birnbaum m.D. 500 U Registrar's Signature

10

D0056296

pper Chesapeak

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

6. Sex

1 □ M 2√2 F

Arweedia

5. Social Security Number

Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-40/5+) 5yrs+ Elementary/Secondary (0-12) 12th grade Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Golden Nettles <u>Israel Knight</u> 19a. Informant's Name/Relationship (Type. Print) <u> Velvert Gholston-Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 3/6/07 22. Name and Address of Facility
March F/H West
4300_Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimo 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, six ck, or heart failure. List only one cause on each line. Imme late Cause (Final Asystole **Physician** dise se or condition resulting in death) /Medical Due to (or as a consequence of): Examine MI (MYOCARDIAL , NEARCTION) Sequentially list conditions, if any, leading to initioalate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit the death certificate be executed Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Hypertension Completed DysRyThMIN CARDIAL 24a. Was an autopsy perforn 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Narsing Home 5 Residence 6 Other (Specify) P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Medical and manner stated. 29b. Signature and title of of tifier 29c. License number 30. Name and address of person who completed cause of death (item 23a) (Type Print) aven Blvd Khosrow abassi,MD15601 Loch 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 6 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 08 31 3 420-48-2846 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2□No Director Baltimore MD NA10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21209 U.S.A. Funeral 6012 Baywood Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married Married 2 X No 1 ☐ Yes 2 No Specify: Specify: ş Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry Baltimore City 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Loyola Northway, Baltimore, Md 21215 20c. Location - City or Town, State Owings Mills, Md 21215 Approximate Interval Between Onset and Death Box 68760. P.0. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gholston

4b. City, Town, or Location of Death

Baltimore

2. Date of Death

TEBRUARY

3. Time of Death

A1

Birthplace (State or Foreign Country)

Year

26,2007

4c. County of Death

31

N/A

Amend Item State of Maryland / Department of Health and Mental Hygiene 26 per verb., 2865,03/16/07dhb

N.

Division or Vital To the Hospital within 24 hours a To the Funeral

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Yulkeary M.V.

betor

29c. License number

-000

600 N. Wolfe Street Baltimore, MD

29d. Date signed (Month, Day, Year)

March

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene And American State of Maryland / Department of Health and Mental Hygiene And American State of Maryland / Department of Health and Mental Hygiene And American State of Maryland / Department of Health and Mental Hygiene And American State of Maryland / Department of Health and Mental Hygiene An

	I	M	end #8 Per FH G865 3/19/07 JH Certificate of Death		Reg. No.	J/ 08284
	Physicia /Medica		1. Decedent's Name (First, Middle, Last) JOSEPHINE GRAVES	2. Dete of De Month	Day	Year 3. Time of Death 1 5 0 am
J	Examine		4e Fecility Neme (If not institution, give street end number) CHERMY LANE NURSING CENTER LAURE		+	Georges
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 1 M 2 F F Residence of Decedent	8. Date of Bi (Month, Da darch 23	19. 2007	9. Birthplace (State or Foreign Country) North Carolina
	show	5	10a. State 10b. County 10c. City, Town or Location D.C Washington D.C Washington D.C			10d. Inside City Limits 1 🕅 Yes 2 🗆 No
	with the Maryla la or 28a-f sho	Director	10e. Street end Number 1400 Florida Ave NE Apt 711 20002		10g. Citizen of V	Whet Country?
020	within 72 hours efter death with the Maryland ena. than "natural", or items 23a or 28a-f show ha Madical Examiner must be notified at	by Funeral	11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent of Hispanic Origin? (Specify: Yes, specify Cuban, Mexican, Puerto R	cify Yes or No lican, etc.)	3- 14. Race Blace Specify	e - American Indian, k, White, etc. BLACK
Maryland 21215-0020	vithin 72 ho na. han "naturi n Medical."	Be Completed	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) House Cleaner	g	16b. Kind of Bu	siness/Industry
land 2	ould be filed v I Mental Hygie arked other t natic event, III	lo Be Co	17. Father's Name (First, Middle, Last) Henry Elliott 18. Mother's Name (Nora Pullima			е)
	and 2 should half half half half half half half half		19a. Informant's Name/Relationship (<i>Type, Print</i>) Jerome Graves, son 19b. Mailing Address (Street and Number or Rural of 15034 Laurelland Pl. Laurel Miles)		er, City or Town,	State, Zip Code)
Baltimore,	permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, tra- once.				Brentwood,	City or Town, State
Bal	Departiment in portion		21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Fleck 7601 Sandy Spring Rd Laure			
	Physician /Medical Examiner	Cyaminer	23a. Per11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pue to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	_		Interval Between Onset and Death
Box 68760,	physicials the bur	E CICS	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
, P.O. I	The lew requires that the death certificate has been signed by the attending page 2 should be detached for use a page 2 should by Dhusinian	y ruysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			tribute to the cause of death? 3 Probably 4 Unknown
Records,	ew requires as been sign 2 should be	ואופופת	GENERAL DEBILITY	24a. Was	an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>	clan: The ertificate hector, page	2	25. Was case referred to medical examiner? Hospital: Hospital: 4 Classical examiner of the control of the cont		one)	1 ☐ Yes 2 No
on of	= = 0		27. Manner of Deeth 1 Naturel 5 Pending 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 1 Naturel 5 Pending 28c. Injury et Work? 28c. Injury et Work?		dence 6 D0the	
Division	e Hospital or Attending P n 24 hours after death. Ne Funeral Director: After t pletely filled in by the funeral		2 Cuiside 6 Could not be	f. Location (City or To		er or Rurel Route Number,
			29a. Certifier (Check only one) 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and place, and manner stated.	I at the time,	date end place, a	and due to the cause(s)
	Vithi To the		29b. Signature and title of certifier 29c. License number 3004521	7	3/1	(Month, Day, Year)
	State		ADE BOWALE ATAILMS 62-DI GREENBELS 31. Dete filed (Month, Day, Year) 32. Registrar's Signature	TRI	Colle	PK MY 2074
	Registrar		MAR 1 6 2007 Brown & Joseph			

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending p for use as t Il Director: / within 24 hours are
To the Funeral Dir

Physician

/Medical

Examiner

Funeral

Director

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ral", or Items 23a Examiner must b

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Ith and Mental I 27 is marked of traumatic even

Department of Health ar Important: If item 27 Is any injury or other trau

Physician

/Medical

Directo

Funeral

Completed by

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

	Sequentially list conditions	b. URINARY W	5 BAYS					
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ACUTE LE Due to (or as a consec	2 WEEKS					
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 爲No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o 9 ☐ Unknown		3d. Date of delivery Month Day Year				
eted by PI	Part II. Other significant conditions of	Yes 2)⊠ No 3						
Somple	THYMIC CARCIN	osy pri ormed? de						
Be (25. Was case referred to medical examiner?	ne)						
	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
tion: T	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		how injury occurred	· · · · · · · · · · · · · · · · · · ·	
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)			28f. Location (8 City or Tox	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)			
	1 Aul	MENICAL NO	(TOA	106493	1	MARCH	11.2007	

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID COSGROVE, JIHNS HOPKINS HOSPITAL, GOD NORTH WOLFE STREET, BALTIMORE, MARYLAND, 21287

Physician National VALERIE STUART CREEN 2 Date of Death March 14 Day 2007 Var 12:03A** 12:03				State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. ?							7 00000	
VALERIE STUART GREEN VALERIE STUART GREEN 46. CG, Ton, of Location of Death Registration Regis							i tilicate of	Dealli		Reg. No.		
Principle Prin		Physici	an						Month	ear		
Funcial Director Proposed Director County Proposed Director County							4h City Town o	or Location of Death	1	4c. County of		
Social Social		Examir	ier			TTUTNC	_			_		
Description Teach	-	Euneral					If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign	
The Store of Part Store of Par				213-46-4846	□M 2 X F	81 Yrs.	Months Days	Hours Min.		400-		
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The properties of the proper		the 1 28a- notifi	rect	10e. Street and Number 10f. Zip Code 10g					g. Citizen of Wha	at Country?		
The properties of the proper		3a or	To Be Completed by Funeral	6451 North Charles Street, #311 21212					Ţ	JSA		
The properties of the proper		deatl		11. Marital Status 12. Was Decedent Ever in U.S.			Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-			
The properties of the proper		after or ite			1 ☐ Yes 2 MTNo							
The properties of the proper		ural",		41	Year or Dates:	100 Deep						
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A Does not be considered the companies of the considered to the cause of death? Due to (or as a consequence of):		withi iene. than		Elementary/Secondary (0-12)		-)	Homemake	r		Own Re	sidence	
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A Does not be considered the companies of the considered to the cause of death? Due to (or as a consequence of):		2 sho and I is ma auma		19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, Sta	ate, Zip Code)	
A Does not be considered the companies of the considered to the cause of death? Due to (or as a consequence of):		and ealth m 27			ler (Daug			t Road,				
A Does not be considered the companies of the considered to the cause of death? Due to (or as a consequence of):	Ore	ges 1 It of H If Ite or ot		·	Removal from State	cemetery, cre	matory or other pla	· ' i			· ·	
Agriculate Agr	ţ	t. Pa rtmen rtant: njury										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and shock, or heart failure. List only one cause on each line. Physician / Medical Examiner Medical Examiner	Bal	permi Depa Impo any is		Macun	wson		MITCHELL	-WIEDEFEI	D FUNERA	L HOME,	INC.	
Physician //Medical Examiner Physician //Medical Examiner Physician // Physici						the death. Do not er	ter the mode of dyi	K Koad, I	Saltimore or respiratory arre	, Maryla	Approximate	
Medical Examiner Part Par		Dhysisian		Immediate Cause (Final	nly one cause on each line. Interval Between Onset and Death							
Sequentially list conditions, farly, leading to immediate conditions. If any, leading to immediate conditions of any, leading to immediate conditions. If any, l				disease or condition resulting in death) a.								
Due to (or as a consequence of): The standard of the standa		Examiner	ner		b	,					/	
Due to (or as a consequence of): The standard of the standa		7 = =		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							24	
February Special Spe		ecuted ind transi	ami	Cause (Disease or injury that initiated events c.								
FFEMALE: 23d. Date of delivery Section Complete	Ő,	oe execian a		resulting in death) Last	Due to (or as a consequence of):							
FFEMALE: 23d. Date of delivery Section Complete	876	cate b	dica	d								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings availab prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 1 Yes 2 No No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 No No 28d. Describe how injury occurred North, Day Year North,	9 X	certifi iding ise as	0 1		23c. If yes, outcome p	of pregnancy				23d Date of	of delivery	
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24a. Was an autopsy findings available prior to completion of cause of death? Yes 20 20 20 20 20 20 20 2		s that med k			/ / / / /	•	ınderlying cause gi	ven in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?	
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29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amount J. Charles M. Charles St. Branna M. 21204	Οį	after after Dire	ertii	4 ☐ Homicide determined	building, etc	. (Specify)					,	
Section Sect		ospita hours ineral y filled										
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 14 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arow J. Charles M. G701 N. Charles St. Branna w 21204		he Ho in 24 I he Fu pletel	edic	one)					urrea at the time, da	ate and place, an	u uue to tne cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arrow J. Charles M 6701 N. Charles St Branna we 21204		Vithi To th	Ž	29b. Signature and title of certifier					2	9d. Date signed (Month, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AANUN J. Charles M 6701 N. Charles St Branna W 21204				· Asc Car	un 1)			יע פר	> 1	yarch	142007	
	_	of the		30. Name and address of person who	completed cause of de	6701 N	Charle	s 5H	Brown	ie un	21204	

State Registrar

DHMH 17 Rev 1/2001 MAR 1 6 200

31. Date filed (Month, Day, Year)

32 pegistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 State of Maryland / Department of Health and Mental Hygiene Per FH G865 3/27/07 JH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 1.33AM March HEAGGANS WALTER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Howard 24355274022 ount Genera olumbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, 1997) 9. Birthplace Country) 6. Sex or Foreign **Funeral** 901-01 1 MM 2□F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. other than "natural", or iteme 23a or 28e-f ehov vent, Ine Medical Examinat transities notified at MD 1 **X**es 2 □ No Saltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Nymber USF 1229 deric Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status Armed Forces?

1 X Yes 2 ☐ No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working

Va. DO NOT use retined) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) ustodian Pather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Heaggans cankin 1/2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Poyte Number, City or Town, State, Zip Code) trederick Kd Dalfmore, MD 21229 Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If eny injury or once. 23/2007 Owings Mills, MD 21. Signature of Funeral Service Licensee Funeral Services Bulto. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Carchovancular DIRCASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2. No 1 ☐ Yes 25. Was case referred to medicat examiner? Be 26. Pface of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred _1—Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

O. Box 68760, Division of Vital Records, P.

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending p ed by the a has been signed 2 should b director this After this Director: led in by within 24 hours a
To the Funerel C

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

it of Health and Mental Hyg if Item 27 is marked other or other traumatic event,

physician a s the burial

Baltimore, Maryland 21215-0036

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State

Registrar

Medica

29a. Certifier

29d. Date signed (Month, Day, Year)

and manner stated 29b. Signature and title of certifier 29c. License number Claure

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March

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** 200 7:50 PM Bette Jane Hemmeter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F Director 219-20-8114 80 Maryland Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at MD 1 Yes 2 No Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7808 Ducks Cove Road 21122 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) oe filed within 7 at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 accountant financia1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 end 2 should be fil ment of Health and Mental H tent: If Item 27 Is marked otl Be Harry Esposito Irene Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Depertment of Health a Important: If Item 27 Is any Injury or other trai Thomas Hemmeter/spouse 7808 Ducks Cove Road Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Sicensee Wade Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Que to (or as a consequence of) ructive Pulmonar Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 27. Many of Death Certification: 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Watural 5 Pending death. 1 Tes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D41365 Wills I T.D. 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 15ptal Drive, Glen Burnie, MD. 21061 32. Registrar's Signature State Registrar

Hemmeter

DHMH 17 Rev 1/2001

Registrar

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		•	For State Registrar	State of Ma	arylanic		rtificate of l			Reg. Nos.	~	00000
			Decedent's Name (First, Middle, Last)						Date of Dea Month		Year	3. Time of Death
•	Physici /Medio		Carlton Eugene H	aulsee					March			7:00 A M
	Examir		4a. Facility Name (If not institution, give s	street and number)				Location of Death			y of Death	
			7927 Oakwood Road	I			Glen Bu		O Data of Dist		Arund	
*	Funeral Director		224-20-3090		e (In yrs. Ia 33	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02/01/	7, Year) 1924	9. Birthp Coun Virg	lace (State or Foreign try) inia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Maryl f sho ied al	ē	Maryland Baltimore		Mic	ddle F	River					1 □Yes 2XNo
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
	th with	a D	1549 Aldeney Avenu	e			21220		Į	J.S.A.		
	ems ser mu	ner	11. Marital Status	12. Was Decedent Armed Forces?		. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2/√Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ I If Yes, Give Year or Dates:	WWI]		1 □ Yes 2 🖾 No		,	Speci		
21215-0036	2 hour	pa	15. Decedent's Edu	cation		16a. Deced	dent's Usual Occup	ation		16b. Kind of 8		
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Maryland	ould be fill Mental Hi arked oth artic eveni	Be	17. Father's Name (First, Middle, Last) Arvel Henry Haulse	0				18. Mother's Name	-		me)	
ryla	should and Men marke	ပ္	19a. Informant's Name/Relationship (Ty.			10h Mailir	ng Address (Street	Daisy Ma		_	State Zin	Codol
Ma	nd 2 sho Ith and 27 Is ma		Barbara Jean Raith	,	iter)		Oakwood I					,
ē,	s 1 ar f Hea iftem 3		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place	i	Date	20c. Location		
E	Pages nent of I int: If Ite		1 Donation 5 Other (Specify)	emoval from State			1 Mem. Ga		9/2007	Balti	more.	Maryland
Baltimore,	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service License	е		22	2. Name and Addres	ss of Facility	i Funora	al Homo	D A	130.27.20.101
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	Physician		Immediate Cause (Final disease) condition resulting in death)									
	/Medical Examiner		Due to (or as a consequence of):									2
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	ence of):	VIIL CA	ruiov	ascui	wi cu	Kun	<u></u>
J7.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
0,	e exector and and and and and and and and and and	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):						
,09289	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical		l								
9 ×	entific ling pl		IF FEMALE:	0- 16								
Вох	eath cer attendin for use	ian/	in the past 12 months?	3c. If yes, outcome 1 □Live birth 4 □ Pregnant at	2 Fetal	death 3□	Ectopic pregnancy Other (specify)	,			ate of delive lonth	ery Day Year
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σ.	w requires that the death cer been signed by the attendin should be detached for use		Part II. Other significant conditions cor	tributing to death b	ut not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to th	ne cause of death?
Records,	quires an sign uld be	Completed by	acuto rena	1a110	lre_				1 🗆 Y	es and No	3 ☐ Prob	ably 4 □Unknown
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		mo							autop perfor 1∐ Yes	rmed? 2 X No	death?	2 No
Vital	ysiclan: The is certificate hε director, page	Be	25. Was case referred to medical examiner?					26. Place of Deat	h <i>(Ch</i> eck only o	ne)		51.1
or \	Physiclan: r this certific ral director,	၉	1 ☐ Yes 2 No	lospital: 1 ☐ Inpatie		R/Outpatier		4 LI Nursing Ho	me 5 Resid	-	ther (Specif	Daughter's Residence
Division or	ding I	ion	27. Manner of Death Natural 5 Pending investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	Worl	y at k? Yes 2 □ No	28d. Describe h	iow injury occu	irred	
İSİ	Attende death death octor:	ficat	3 Suicide 6 Could not be				eet, factory, office	100 2 110	28f. Location (S	Street and Num	ber or Rura	I Route Number,
<u>S</u>	al or / s after il Dire	Certification:	4 ☐ Homicide determined	building, et	c."(Specify)				City or Tow			
	ospita hours unera ly fille	Sal	29a. Certifier (Check only 2 Medical Exami	sician: To the best	of my know	rledge, deat	n occurred at the tir	ne, date and place,	and due to the	cause(s) and n	nanner as s	tated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one)	and manner st		on anaron III						
	To To	2	29b. Signature and title of certifier	1/-		NI	29c. Licenso	23 RI	1	29d. Date sign	ed (Month,	Day, Year)
			Victoria	val	MIL	MIL	1, D3	001		nuich	101	200 1
	14		30. Name and address of person who co	mpleted cause of d	eath (Item :	23a) (Type,	Philadel	phia Rd	#304 7	3aHI'mi	DAY. M	2007
<	Sta	te	31. Date filed (Month, Day, Year)	32, Registr	ar's Signati	ire /	را در حرور	1 1000			// /	

Registrar

32, Registrar's Signature

MAR 1 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

-	Sta Registr	- 1	31. Date filed (Month, Day, Year) MAR 1 6 2007	1					
	5		30. Name and address of person who completed cause of death (Item 23a) (10 ung J. Lee 300 l 5. Ho	Type, Print)	Balt	inore	mo z	122	5
	/ 3 4 8							/13/	07
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(check only one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier		se number		date and place, as 29d. Date signed		
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and	, death occurred at the t	ime, date and place,	and due to the	cause(s) and man	ner as st	ated.
Division or	after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Could not be determined 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)			28f. Location (S City or Tow	Street and Number vn, State)	r or Rural	Route Number,
ou o	ing Affer une			Time of 28c. Injury Wo	ıry at ork?] Yes 2 ☐ No	28d. Describe h	now injury occurre	d	
	hysici this cer	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	thatterit 3 DOA	her: 4 Nursing Ho	ome 5 K Resid	dence 6 Other)
Vital F	Physician: The law this certificate has trail director, page 2 s		25. Was case referred to medical		26. Place of Deat		2 No 1	Yes	2 No
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rds,	w requires the been signed should be d	ام ا	Taken. Sand algorithmatic communities continuoung to death but not resulting in	i are underlying cause gi	von IIII ait I.	1 💢			abiy 4 🗆 Unknown
P.0.	res that the de signed by the a be detached f		9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in		ven in Part I	23e. Did tr	obacco use contrib	oute to th	e cause of death?
Box	ath cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	cy		23d. Date Mon		ry Day Year
68760,		ledical	d						
60,	ificate be executed g physician and as the burial-transit		resulting in death) Last C. Due to (or as a consequence of	of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	of):					
	Examiner		Due to (or as a consequence of	or):					
, i	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Mutas47	atic hi	ing a	encer	-		Interval Between Onset and Death 3 mo \$
Ä	a III		23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	1 Second A	venue Sw	Glen Bu	rnie, MD	210	61 Approximate
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or of		XIBUNAL 2 Cremation 3 Chemoval from State	n Park Ceme	etery 20 ess of Facility Si	07 ngleton	Baltim Funeral	Hom	e, P.A.
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Mary	d 2 should th and Men 7 Is marke traumatic			Mailing Address (Street 8 Broadway			-		
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d 21	filed w Hygier Ather th	ပ္	2 Co	mmunication	18. Mother's Name	e (First, Middle,	Electro Maiden Surname		
215	ithin 72 ne. Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of work	ing			
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ed by	3 Wildowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🕅 No Decedent's Usual Occu	pation		Specify:		
'	r tems	Funeral	11. Marital Status 1 □ Never Married 2 M Married 1 □ Never Married 2 M Married 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes, S □ No If Yes, Give	13. Was Decedent of I		ecify Yes or No- Rican, etc.)	1	, White, e	etc.
	ath with		308 Broadway Avenue	210			U.S.A.		
	r 28a-	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of Wh	nat Count	try?
	Aarylan f show ed at	ō	10a. State 10b. County 10c. City, Town MD Anne Arunde1 Glen I	or Location Burnie				10	0d. Inside City Limits 1 □Yes 2 ☑ No
	Director		Usual Residence of Decedent			Dec. 5	, 1944		MD
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec • 5	h v, Year)	9. Birthpl Count	ace (State or Foreign
	Examin	er	4a. Facility Name (If not institution, give street and number) 308 Broadway Avenue	4b. City, Town, o	or Location of Death		4c. County o		de1
	Physicia /Medic		Raymond J.	Halfter		Month March	12, 200		8:08P M
**			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of	Dealli	2. Date of Dea		11	3. Time of Death
			For State of Maryland / D	Certificate of					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend tate of Maryland / Department of Health and Mental Hygiene Per FH G865 3/16/07 and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:20 PM 2007 ON March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Gity, Town, or Location of Death Examiner 171 TOST more 7. Age (In yrs. last birthday, 8. Date o Birth (Month Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. 214-40-9847 Months Hours 1X M 2□ F 3 Yrs. MARYLand Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Baltimore 1 to 2 □ No Md Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number LERN AVE 21213 USA 4102 Bal Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the stith and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Mamied 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: BLACK Specify: <u></u> 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construc 100 BRICK ayer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be amilton MARKE UKN P 19b. Mailing Address (Street and Number or Runal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trans Md. 21213 Sister 4102 estelle Balterr 0. 60 ston 20b. Place of Disposition (Name of cemetery, crematory or other place) Dațe 20c. Location 3 City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Balto 4 Donation 5 □ Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee permit. ller's Methipolitan Chapel BROAdway Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, owneart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMIA **Physician** /Medical Due to (or as a consequence of): EPSIS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**X** No 1 Yes l or Attending Physician: after death. neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[**X** No 1 Yes 1 Linpatient 3□ DOA 2 ☐ ER/Outpatient ို 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No М 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 2 POS-000 MODILITZ DOCIGI NAUDIA N. HAUMOR. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21237 JOHNSHOPIUMS HISPITMI, GOT NORTHWOLFE STREET, BAUTIMORE, MARYLAND N. LAWDER 31. Date filed (Month, Day, Year) MAR 1 6 2007 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			State of Maryland	-	rtment of H			giene Reg. No.	117	09293					
10 A	*		Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	Voor	3. Time of Death					
	Physicia /Medic		Dewaine Curtis Hillenburg				March	13, 2	0 0 7	11:00 A M					
	Examin		4a. Facility Name (If not institution, give street and number) 12423 Eastern Avenue		4b. City, Town, or Baltin	10re	1	4c. County	of Death altim	ore					
200	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 220-13-0956 1 ₹ M 2 □ F 35	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Oct. 8	v, Year)	Coun	lace (State or Foreign try) yLand					
-	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, To	own or Loc	ation				1	0d. Inside City Limits					
	Maryl f sho ied at	ľo	Maryland Baltimore	Ва	altimore					1 □Yes 2 No					
	r 28a notil	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	itry?					
	ath will		12423 Eastern Avenue			220			s.A.						
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:		/as Decedent of Hi Yes, specify Cuba □Yes 2X No	spanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Specif	ce - Americ ck, White, y: Wh						
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Baltimore, Maryland 21215-0036	ould be Mental arked o atic eve	To Be	Norman T. Hillenburg, Jr.			Margare									
Mar	d 2 sh th and 7 Is m traum		, , , , , , , , , , , , , , , , , , , ,	-	g Address <i>(Street t</i> Uni versi			-		·					
Ē,	f Heali fem 2		20a. Method of Disposition 20b. Place		sition (Name of natory or other place		Date	20c. Location							
E	Page: nent o int: if i		11/4 Burial 21 ICremation 31 IBernoval from State 1		L Mem'l		7/2007	Baltimo	re, 1	Maryland					
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licenses		Name and Addres				2 Home 21236	28					
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ente	r the mode of dyin	g, such as cardia	or respiratory ar	rest,		Approximate Interval Between					
	Physician	ĺ	shock, or heart failure. List only one cause or each line. Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death												
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Vit	Physician; r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER	1/Outpotion	Othe	or.	ath (Check only o		(2)						
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ion	Attending r death. ector; After by the funer	atio	2 Accident investigation March 13,2007 11	O4 A		Yes 2 No	selt wy	To head	1m3						
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle physician on the basis of examination and manner stated.	edge, death	occurred at the tir		e, and due to the	cause(s) and m	anner as s						
	To th withii To th	Me	29b. Signature and title of certifier		29c. License	1 1		29d. Date signe							
			My Deputy		D18	661	<i>i</i>	March	15,20	507					
	12		30. Name and address of person who completed cause of death (Item) 23	3a) (Type,	e Will	CT. L. 41	all: oran	e Md	21	093					
8	Sta Registi		30. Name and address of person who completed cause of death (Item 25) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Gos	well !			V							

			State of Maryland		artment of H		nd Mental H	211	ette P	n8294			
2:		-	Registrar 1. Decedent's Name (First, Middle, Last)		inicate of i		2. Date of D	Reg. No.	U I	3. Time of Death			
	Physici		Shirley S. Hensch	en			March	12, Day 200	7 Year	5:43 P M			
	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of			y of Death	31.0			
			10 Margate Road			ervill		Ba	ltimo	re			
型件(Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las.	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B	Day, Year)	9. Birth	place (State or Foreign			
	Director	,	267-30-9770 85 Usual Residence of Decedent	115.			Feb.	17, 1922	Ma	rýland			
	yland low at		10a. State 10b. County 10c. City, T	Town or Lo	cation					Od. Inside City Limits			
	e Mar a-fsk tified	ctor	Maryland Baltimore L	uther	ville					1 □Yes 2X No			
	or 28	Dire	10e. Street and Number		10f. Zip Code	_		10g. Citizen of		ntry?			
	s 23a	eral	10 Margate Road	T40.1	2109		-0./Cif. V h		.S.A.	oon Indian			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Mas Decement of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	spanic Originan, Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)	Bla Speci	ack, White,	etc.			
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Maryland 21215-0036	l be fil ntal H ed ott	Be	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First, Middl		•				
Ž	should nd Me mark matic	2	Robert E. Shock 19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	a Address (Street a	and Number	Edna or Rural Route Num	M. ther City or Town	Gemn				
Ma	nd 2 salth ar 27 is r trau		William R. Henschen Step-son		Jupiter H					nd 21012			
ore,	es 1 and 2 of Health a litem 27 is r other trai		20a. Method of Disposition 20b. Plac		sition (Name of natory or other place		Date	20c. Location					
ij	Page ment ant: If ury ol		I Dunai 2 La Cremation 3 Demondration State	top S	ervice Co	orp. 3	-14-2007	Towson	Ma	ryland			
Baltimore,	permit. Depart Import any Inj once.		21. Shipethia A Pineral Service Licensee		Name and Address		RuckTowson.	on Funer Marylan		me, Inc. 204			
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9	sertific	/Mec	IF FEMALE:										
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	eath 3	Ectopic pregnancy Other <i>(sp</i> ec <i>ify)</i>				ate of delive onth	ery Day Year			
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Division or Vital Records,	or Attencather death Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office	11.00	28f. Location	(Street and Num.	ber or Rura	al Route Number,			
ō	ital or A rs after ral Directed in by	Cer					ony or 7	own, oldio					
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tin restigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	e cause(s) and m e, date and place	anner as s , and due t	tated. o the cause(s)			
	To the le within 24 To the Complet	Me	29b. Signature and the of certifier		29c. License	e number		29d. Date signe	ed (Month,	Day, Year)			
			bilyutth MD Deput.	Y	018	667		March	13,2	.007			
	12	1	30. Name and address of person who completed cause of death (Item 23)	Ba) (Type, I	Print)	athon	ville Mi	2100					
	Sta		31. Date filed (Month, Day Year) _ 32. Registrar's Signature				ı						
	Registr	ar	MAD 1 C 2007	· Ca	est !								

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2205 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 March 5:55 PM RICHARD HARRY HART 200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Roland Park Place Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. January 5, 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) X1X M 2 ☐ F 99 MaryTand 214-40-5803 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ¥XIYes 2□No Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 USA 830 West 40th Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Public Library 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Murphy Harry Hart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Suzanne P 0'Connell PR 1802 Thornbury Road Baltimore, Maryland 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GreenMount Crematory 3/15/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arteriosclerofic cardiasascular advan ced ears Due to (or as a consequence of): ave use if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy performed? Yes 2 100 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 □ Pending investigation 1 ☐ Yes 2 ☐ No M 2 ☐ Accident 6 ☐ Could not be

Examiner certificate be executed attending physician and for use as the burial-transit Box 68760, ned by the atten detached for u P.0. signed by the period of the pe Division or Vital Records, as been signal 2 should b has funeral director, this

Physician

/Medical

Examiner

10a. State

Funeral

Director

natural", or items 23a or 28a-f show Jical Examiner must be notified at

other traumatic event, the Medical

Physician

/Medical

within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

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Certification:

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Q

State Registrar

MISABELLE

29b. Signature and title of certifier

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 013657

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) March 14, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EREG3

830W. 40th STREET, BALTIMORE, M) 21211

31. Date filed (Month, Day, Year)

determined

Kathleen Coyle			e or Print in Bla c e of Maryland / [Depart	ment c	of Health ar			egible.	200	7 6350
Dhyaiai		Registrar 1. Decedent's Name (First, Middle, L	act	Certi	ficate c	f Death		2. Date of De	Reg. No.	400	1 USES
Physici Medical Exami			NE COYLE HICE	KS				Month March 12	Day	Year	3. Time of Death 2215 hrs
		4a. Facility Name (if not institution, 7515 Iroquois Road Av	give street and number)			4b. City, Town, o			4c. (County of Deat altimore Cou	
Funeral			Sex 7. Age (I	In yrs. last	birthday)	If Under 1 Ye	_	A disc	•	Forei	rthplace (State or
Director		212-82-5025 1	M 2XF	47	Yr		ys Tiodis	Jan	19, 1	.960 cd	ountry) Marylan
any		10a. State 10b. County	10	c. City, To	wn or Loca	ition					10d. Inside City Limits
land f show	ō		ore County	S	parro	ws Point					1 Yes 2 X No
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene, unt: If time 17 is marked other than "natural", or items 23a or 28a-f show any re other trannatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 7515 Iroquois A	Avenue			10f. Zip Code	1219		10g. Citize	en of What Cou USA	ntry?
th with	Funeral	11. Marital Status 1 Never Married 2 X Marri	12. Was Decedent Ev	er in U.S.		as Decedent of Hi Yes, specify Cuba		i? (Specify Yes or N Puerto Rican, etc.)	to- 14	4. Race - Amer White, etc.	ican Indian, Black,
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hours a	ed by	15. Decedent's Education (Specify	only highest grade comple	eted) 1	Sa. Decede	nt's Usual Occupa	ation (Give kir	nd of work done	16b. Kin	nd of Business/	Industry
36 iin 72 h han "r dical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+		Ü	hotherap		se retired)	Me	ental H	lealth
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Com	17. Father's Name (First, Middle, La	_			1		Name (First, Middle,	Maiden Su	urname)	
1218 d be filk ental H arked	Be	Richard Foley						len Agath			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", injury or other transmetic event, the Medical Examiner.	٩	19a. Informant's Name/Relationship David A. Hicks	(Type, Print) (Husband)		7515	Iroquoi	.s Aver	er or Rural Route Nu nue, Spart			
or Heal		2Ca. Method of Disposition 1 Burial 2 Cremation	3 Removal from State	cre	matory or o			Date		cation - City or	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Spec	ify:	Gree		nt Cemet	_	3/16/2007	- 1		, Maryland
Baltil permit. Departm Importa			rwan		MI	TCHELL-W	I EDEFI	ELD FUNERA Baltimore	AL HOI	ME, INC	21212
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/Medical Examiner		Immediate Cause (Final disease	a Asphyxia								Death
		or condition resulting in death)	Due to (or as a conseque b.	ience of);							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of):							
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	sician/Medical	IF FEMALE:	23c. If yes, outcome of	of pregnar	, 3/22/	0/ TT			23d. I	Date of deliver	<u> </u>
687 certific ding p	jan/l	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at tim		2 F	etal death 3	Ectopic p	regnancy			Day Year
Box death of the atter d for us	ysic	1 Yes 2 No 9 V Unkno	17	ie oi deali	5 0	ther (Specify)			66		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	by Phy	Part II. Other significant condition	s contributing to death bu	ut not resu	Iting in the	underlying cause	given in Part				the cause of death?
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ion of tending Pheath.	T:U	27. Manner of Death 1 Natural 5 Deadles	28a. Date of Injury (Month, Day, Year)) 28	b. Time of		iry at Work?	28d Describe			
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Division spital or At hours after dineral Direct y filled in by	ertif	Suicide 6 Could n 4 Homicide	ot be	er-sce		ict, radiory, omice	building, oto.	or Town.	State)		Ltimore, MD
Hospital 24 hours : Funeral etely filled		29a. Certifier 1 Certifying Phys	ician: To the best of my kr					e, and due to the cau	ıse(s) and ı	manner as stat	ed.
To the Howithin 24 b To the Funcompletely	Medical		ner: On the basis of examin and manner stated	ation and/	or investiga			rred at the time, date			
	2	29b. Signature and title of certifier	M			29c. Licen:			1	ite signed <i>(Mo</i> h 13, 2007	ниг, рау, үеаг)
Land and	1	30. Name and address of person wh	to completed cause of deat	th (Item 23	a)					,	
12 Ch Doug		Zabiullah Ali, M.D. As	sistant Medical Exar	miner		n Street, Bal	timore, MI	21201			
St Regist		31. Date filed (Month, Day, Year)	32. F gistrar's \$	Signature							

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		For State		epartment of Health ar	nd Mental Hygier	1e 2 11 17 11 18 29 7
		- State Registrer		Certificate of Death	Rag. N	vo.
Dhw	ician	1. Decedent's Name (First, Middle, Last)	A / 2 ! ·	1 -1-0.00	2. Date of Death Month	3. Time of Death
	dical	LIOVA	Nathani	el James	March 13	5,2007 6.39PM
	niner	4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location of I	Death /	c. County of Death
		4192 Sw	Hand Road #20	1 Sut1a	nd	frince Georges
Fune		5. Social Security Number 6. Sec	14 200	Months Days Hours	Hrs. 8. Date of Birth Min. (Month, Day, Yea	9. Birthplace (State or Foreign Country)
Direct	or	125 16 72+0	39 Y	rs.	July 25,1	952 Virginia
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
lanyla	5	1 1 1 1	0	Swilland		1 ☐ Yes 2 ☑ No
the N	ect	Maryland Trince	Georges	10f. Zip Code	100 /	Ditizen of What Country?
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death with the Maryland rins 23a or 28a-f show	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13 Was Decedent of Hispanic Origin	2 (Specify Ves or No-	14. Race - American Indian,
ter d	Ë	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 	Puerto Rican, etc.)	Black, White, etc.
C Z I Z I D-UUSO filed within 72 hours after Hygiene. ther than "neturel", or ite	þ	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates: 10/74-10/19	1 ☐ Yes 2 No Specify:		Specify: Black
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other other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle, Maid	en Sumame)
y farro A y farro A buld be filed Mental Hygi arked other etic event.	To E	Edgar	James	(se	raldine	Cottman
Exposite standard Men and Men is marke	-	19a. Informant's Name/Relectionship (Ty	pe, Print) 19b.	Mailing Address (Street and Number of		y or Town, State, Zip Code)
intimore, Waryiatta Z I Z 13-0030 int. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene. ortent: If them 273 in marked other than "neturel", or Items 23a or 28a-1 show injury or other treumatic event, Item Market Exeminant be notified a		Jacqueline Jame	es-Wife 47	17 A Cardinal C	ourt East Ric	hmand Va. 23228
of He	1	20a. Method of Disposition		Disposition (Name of r, crematory or other place)	Date 20c.	Location - City or Town, State
Dallingor permit. Pages Department of Importent: if it		1 Burial 2 Cremation 3 F '4 Donation 5 Other (Specify)	emoval from State	artist Church Centery 3	121107 W	iliamsburg Va.
Dalling permit. Pag Department Importent: I	ġ	21. Signature of Funeral Service License		22. Name and Address of Facility		23185
Deg deg	SUCE	Robert B !	Salw HV	Whiting's Funeral	Home 7345 f	ocuhartas Trail Withansbury K.
11/50		23a. Part1. Enter the disease, or complishook, or heart failure. List only or	cations that cause the death. Do no			Approximate Interval Between
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/Medic		disease or condition resulting in death)	Due to (or as a consequence o		ance 10 -	iver 5 months
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ath cer ttendir or use	an/	23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delivery
	Sici	in the past 12 months?	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
at the laby to stack	Physician/Med	9 Unknown				
VII.d. THE COI US, F.O. DOX 00 sicien: The law requires that the death certificat certificate has been signed by the attending phy rector, page 2 should be delached for use as the	þ	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to the cause of death?
w requires to been signer should be	ted				1 🗆 Yes	2 No 3 Probably 4 Unknown
taw r as be	ompleted				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The The ate h	Con				performed? 1 ☐ Yes 2 🔀	
Attending Physicien: The tay of death. ector: After this certificate has by the funeral director, page 2	Be	25. Was case referred to medical examiner?			Death (Check only one)	
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r Attending ter death. irector: Afte	Certification:	2 Accident investigation		M 1 Yes 2 No	-	
r Att	ŧ	3 Suicide 6 Could not be determined	28e. Płace of Injury - At home, fan building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
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Ditel of urs af			sician: To the best of my knowledge,	death occurred at the time, date and polynomial for investigation, in my opinion, death	place, and due to the cause occurred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
Hospitel of 4 hours af Funeral D		(Check only 2 Medical Examin	tor. Off the basis of examination and			
the Hospitel c hin 24 hours af the Funeral D	edical	(Check only 2 Medical Examination)	and manner stated.	29c Licence number	204 0	Date signed (Month Day Veer)
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filed in by the funeral director.		(Check only 2 Medical Examin	and manner stated.	29c. License number		Date signed (Month, Day, Year)
To the Hospitel c within 24 hours at To the Funeral D completely filled in	edical	(Check only 2 Medical Examination) 29b. Signature and title of certifier	and manner stated.			
To the Hospitel c within 24 hours af To the Funeral D completely filled is	edical	29b. Signature and title of certifier 30. Name and address of person who co	and manner stated.			
8	edical	(Check only 2 Medical Examination) 29b. Signature and title of certifier	and manner stated.			Salfimore, Md. 21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12 a M **Physician** Edith Johnson Lucille 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Franklin Square 5. Social Security Number 6.5 Rose Cale
Under 1 Year If Under 24 Hrs. Hospital Center Itimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
April 12,1922 West Virginia Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 □ F 84 Director 723 07 8905 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 953 Martin Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married J oh Nンon, トルピール Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "I any Injury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel C. Kelly Charles Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lucinda Waterfield (daughter) 953 Martin Road Essex Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc 3/15/2007 |Baltimore Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex MAryland 21221 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. F. rt1. Enter the disease, or con sh. ck, or heart failure. List only Immedia ey ause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death 3dau 5 **Physician** y POLIA (or as a consequence of): /Medical **Examiner** ue to for as a conservence of: Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ending physician and use as the burial-transit Thuid Duer load Due to (or as a consequence of): Box 68760, Renal Physician/Medical tailure IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant signed by the atten 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Atrial fibrillation 1 🗌 Yes 2/X No 3 Probably 4 Unknown page 2 should Completed Secondary 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Right thoracoplasty 24a. Was an this certificate 1□ Yes 2 X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funeral I 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Begistrar

DHMH 17 Rev 1/2001

Registrar

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MAR 1 6

31. Date filed (Month, Day, Year)

Franklin Square Drive

Da Himore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Maryl		artment of H			ene 007	08299
	0		1. Decedent's Name (First, Middle, Last,)	- /			2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		CORDELIA	JOHNS	50~			MARCH	13 2007	9:50A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
Н	,		CATONSVILLE CO				SVILLE		BALTI	
	Funeral		5. Social Security Number 6. Sec. 1218-22-7548	7 07 -	yrs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		Usual Residence of Decedent	Λ 0	55			11/04/	1921 MA	RYLAND
	yland yland		10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	a-f s	cto	MD BALTIN	1ORE	CATONS	SVILLE				1 ☐ Yes 2½ No
	or 28	Director	10e. Street and Number			10f. Zip Code	000	10	g. Citizen of What Co	intry?
	death with the Maryland ms 23s or 28s-f show rmust be notified at	- a	16 FUSTING AVI				228		USA-	4.
9500	hin 72 hours after death with the Marylan B. Me Jical Eraminer must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 [X]No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: BL	, etc.
ဂ	72 ho	etec	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occup- kind of work done	ation during most of workii l)	ng 1	6b. Kind of Business/l	ndustry
V	vithin ne. han *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired HOMEMAKE			DOMEST	TC
V	Hygie Hygie ther t		12TH 17. Father's Name (First, Middle, Last)			IOHIDHIKE	18. Mother's Name	(First Middle M.		
/lan	uld be Vental Irkad o Itic ava	To Be	JARRITT SMITH					NIA AND		
Mar	nd 2 sho lth and 27 Is mu		19a. Informant's Name/Relationship (T) HARRY B JOHNSON			-			City or Town, State, Z	
re,	of Healt fitem 2 r other	15.5	20a. Method of Disposition	20	0b. Place of Dispo	sition (Name of natory or other place	:e) D	ate 20	Oc. Location - City or	own, State
Ē	artment of crtant: If it injury or o		1 XBurial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	BALTÎM	PARTERY OF Other place ORE NATI EMETERY	ONAL 3/	19/07	BALTIMOR	E,MD
Бапптог	permit. Page: Department of Important: If i any Injury or		21. Signature of Suneral Service Licens) 22	. Name and Addres	ss of Facility HO		NERAL HO	
			23a. With Enter the disease, or comp	ications that caused the ne cause on each line	-3				· ·	Approximate Interval Between
	Physician		Immedial Cause (Final dis-se or condition resulting in death)	aCov	onery	aste	my Si	cash		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):	Lem/	0			, 0, ,
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בר בר	be executed ician and burial-transit	Examin	resulting in death) Last	Due to (or as a cor	nsequence of):					
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X D	death certifi e attending id for use as	Physiclan/M	in the past 12 months?	23c. If yes, outcome of pri 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliment	∕ery Day Year
o	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ordeath 5	Other (specify)				
7	es that igned to be deta	þ	Part II. Other significant conditions co	ntributing to death but no	t resulting in the w	nderlying cause give	en in Part I.		acco use contribute to	. /
Hecords	v requir been s should	leted						24a. Was an	24h Were au	opsy findings available
ě E	sician: The law s certificate has b lirector, page 2 s	ompl						autopsy perform	ed? prior to death?	ompletion of cause of
	an: T tiftcat or, pe	Ö	25. Was case referred to medical				26. Place of Death			2 No
>	Physician: this certific ral director,	0.0	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Oth	/		ice 6 Other (Spec	ify)
on oi	ding Phys h. After this tuneral di	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	Worl		28d. Describe how		
INISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str pecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru. State)	ral Route Number,
2	pital o	Se	29a, Certifier 1 Certifying Phy	sician: To the best of my	kanuladan dasti	a convened at the tra	no, data and place	and due to the neu	una(a) and mannor as	stated
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	(Check only one)	iner: On the basis of examination and manner, stated.	mination and/or in	vestigation, in my o	pinion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
	To the within Fo the complex	Me	29b. Signature and title of certifier	Atte	~ lip	29c. Licens	e number	29	d. Date signed (Month	, Day, Year)
			De La	0.	ms'	Di	36942	_ ^	reach 16	1, 2007
	4		30. Name a address of person who co	ompleted cause of death	(Item 23a) (Type,	Print)	P) (04	~ 2/1/0	My 2-	Day, Year) 1 2 2 8
	Sta	te.	31. Date filed (Month, Day, Year)	32. Ragistrar's S	Signature.	ever 1	0. 770	- 10,00	, , ,	J .
=	Registr		MAR 1 6	2007	JA K	DENES				

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2007 March 13, 1:00 am Robert /Medical Kreppel 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3815 Bayville Road Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1**X** M 2 ☐ F Yrs. 11/13/1934 Director 72 Maryland 215-30-5073 Usual Residence of Decedent liled within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or iteme 23s or 28s-1 ehow other traumatic event, it a Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3815 Bayville Road 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1954 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Completed by 3 Widowed 4 Divorced 1958 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Steel Mill Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Frederick Thomas_ Kreppel Frances Bertha Sollers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River, Maryland 21220 Patsy Rue Kreppel (Wife) 3815 Bayville Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: If Ite
eny Injury or ot 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3/16 2007 Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Functal Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease condition resulting in death) I ve bo avas a **Physician** d sease cavs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to initirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, ettending physicien for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 🖾 No page certificete Scirwe al scrker 2 No 1 Yes within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 \(\triangle \text{ Nursing Home} \) 5 \(\text{X} \text{ Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Medical Certification; To 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ANatural 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1041614 mo Mare 14,2007 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21236 Hay w halle 31. Date filed (Month, Day, Year) 32. Registrar's Signa State MAR 16 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month 200[°]7 **Physician** 11:45PM March $1\bar{4}$ Kucz Wayne Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk 1213 Delbert Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Hours Days Months **№** M 2 F 55 213-54-4724 Maryland July 25,1951 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show r 28a-f show notified at 1 ☐ Yes 2X No Baltimore Dundalk Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21222 USA 1213 Delbert Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14 Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. altimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry th and Mental Hygiene.
7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Improvements Self Employed 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian V. Smith Bernard F. Kucz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trauonce. 7523 Berkshire Road, Dundalk, MD. 21224 Lillian V. Kucz Mother Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 19, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore City, MD. Bayview Crematory 2007 4 ☐ Donation 5 ☐ Other (Specify) Igna ure of Furleral Service Licen_e 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG **Physician** CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Each of John Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □ Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the nospector within 24 hours after death.

To the Funeral Director: At 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hospital 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifier HEMATOLOGIST D-51555 MD UNLOLGGIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE \$2200 BALTIMORE MD 21237 9103 FRANKLIN SOURCE SGIN AUNG Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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James Harvey Kis	1	- For State	State of Maryla		artment o ertificate o		and I	Mental H			107	0830
Physician Medical Examine	1/	Registrar 1. Decedent's Name (First, Mid James Harvey					-		2. Date of De Month March 14	ath Day Year		Time of Death 0702 hrs
		4a. Facility Name (if not institut 5 Slipstream Court		ımber)		4b. City, Tow Middle		cation of Death		4c. County of Baltimore		
Funeral Director	;	5. Social Security Number 215–46–8079	6 Sex	7. Age (In yrs.	last birthday) 60 Yrs	If Under Months	Year Days	If Under 24Hrs Hours Min		irth(MM/DD/YYYY) /1946	Foreign	ce (State or Maryland
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Maryland r 28a-f shed at one	<u> </u>	10e. Street and Number	imore	MIC	ate kiv	10f. Zip Co		-		10g. Citizen of Wha		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event. The Medical Examiner must be notified at once.	- ∟	5 Slipstream C 11. Marital Status 1 Never Married 2 1	12. Was Dec Armed F				of Hispai	nic Origin? (Si lexican, Puerto	pecify Yes or N Rican, etc.)	U.S.A. o- 14. Race - White,		Indian, Black,
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MD 2 1d 2 shoul 1d 2 shoul alth and M 27 is m T	_	Patricia Kisne 20a Method of Disposition				ansvei	se z	Avenue,		nore, Mar	yland	21220
Baltimore, permit. Pages I an Department of He Important: If ite Important: If ite Injury or other tr		Burial 2 X Crematic Donation 5 Other :		rom State	crematory or o	ther place)				7 Baltimo		
Balti permit. Departu Import. injury	1	21. Signature of Funeral Service			22. l	Name and Action 107 Old	dress of Bruzo Ea:	gacility dzinski stern <i>P</i>	Funera Venue,	al Home, Essex, M	P.A. aryla	
Physician /Medical Examiner		23a. Part I, Enter the disease, of failure. List only one caus Immediate Cause (Final disease)	se on each line. se a. <mark>Contact sh</mark>	otgun Wour	nd of chest	the mode of o	dying, su	ch as cardiac d	or respiratory a	rrest, shock, or hea	rt A	pproximate Interval Between Onset and Death
	_	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b	a consequence								
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D, be e: siciar	edical	UNPENDED	AMENDED							Tag and		
Box 6876 e death certificate the attending phy ed for use as the 1	sician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	1 Live I	nant at time of o	2 F	etal death other (Specify	3	Ectopic pregna	ancy	Month	Day	Year
P.O. E es that the est the est that the est that the est that the est that the est	2	Part II. Other significant cond	ditions contributing t	to death but not	resulting in the	underlying ca	ause give	en in Part I.		tobacco use contrit es 2 No 3		
Division of Vital Records, P.O. Box 68766 the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death the Funeral Director: After this certificate has been signed by the attending phy uppetely filled in by the funeral director, page 2 should be detached for use as the broad of the control	Completed						-		1 🗸 Yes	opsy proformed? d		sy findings available sletion of cause of 2 No
Vital ysician:	o Be (25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier		IO:	Death (Check	ng Home 5	Residence 6	Other: Sc	ene
ion of tending Pheath	ation: T		28a. Date (Mont FOUNL vestigation Mar 14	e of Injury h, Day,Year)): , 2007	28b. Time of FOUND: 0657 hrs			at Work? s 2 ✓ No	Subject sh			
Division To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fur	Certificati	3 Suicide 6 Co	ould not be etermined (Specify	yard	home, farm, stre				or Town, 5 Slipstream	Court, Middle R	iver, MD	Route Number, City
thin 24 h	Medical (Physician: To the be xaminer: On the basis and manner_	of examination								use(s)
	Me	29b. Signature and title of certification		sidiod.			icense r			29d Date signe March 14, 2		Day, Year)
lût1			ssistant Medical		^{m 23a)}	Street, Ba	iltimore	e, MD 2120	11			
Sta		31. Date filed (Month, Day, Yea	2007 32 A	Registrar's Signa	ature Ana	ell s						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Item 1 State of Many and 639287 70941 of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Robert 3. Time of Death Joseph **Kipikas** Month Yee MAU -10:00AM 2007. 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Death Baltimore

If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)

- 12 10 1351 S. Clinton Street If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1**X**M 2□ F Deys Months 200-22-3115 PA Dec. 12, 1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 11∏ Yes 2 □ No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1351 S. Clinton Street 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Kipikas Helen Sumski 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Taylor 56 Brakeman Drive, Stewartstown, PA 17363 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 3/14/07 Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE Due to (or es a consequence of): Degree to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1XYes 2□ No 3 ☐ Probably 4 ☐ Unknown egeneration 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 **X**No 1 ☐ Yes 2 No

Physician /Medical Examiner

Physician

* /Medical

Examiner

Director

Funerai

à

Completed

Be

Funeral

Director

parmit. Pagas 1 and 2 should be filad within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiene. Important: If Item 27 is merked other then "natural", or items 23s or 28a-f show any fulury or other traumatic event; the Musical Examinat must be notified at once.

altimore, Maryland 21215-0020

Examiner Physician/Medicai \$ Completed Be

1 ☐ Yes 2 No

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 - Homicide

The law raquiras that the death certificate be executed ad by the attending physician and datached for use as the bunal-translt or Attanding Physician:

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartific completely filled in by the funeral director, Certification: To edicai

041

State Registrar

25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

26. Place of Death (Check only one)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 02080

W. Greenp

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) JonkoFF ·D K 10

2. Registrer's Signeture

31. Date filed (Month, Day, Year) 6 2007

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certific

30. Name and address of person

31. Date filed (Month, Day, Year)

ORIGINAL

29c License number

29d. Date signed (Month, Day, Year)

and manner stated

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Frank Ryan, M.D. 11701 Livingston Road, Fort Washington, MD

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>			giene Z	U /	08305
1	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Elaine G. Lak: 4a. Facility Name (If not institution, giv.		1	4b City Town or	Location of Death	March	4c. County	007	10:00P M
	Examin	er	2901 Boston St				more Cit	у	40. Ocumy	OI DOG!!!	
Ī	Funeral Director		219-32-2031	ex	ge (In yrs. last birthday O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 4 - 2 6 - 1	936	9. Birthy Cou	place (State or Foreign ntry) MD
	land Sw		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1.	10d. Inside City Limits
	death with the Maryland me 23a or 28a-f show	tor	MD		Baltim	ore City	У				1. Yes 2 □ No
	ith the or 284	Olrec	10e. Street and Number			10f. Zip Code		1	10g. Citizen of V	Vhat Cou	ntry?
	e 23a	erall	2901 Boston St			21224		and Van as Na	USA	o Amadi	can Indian,
336	within 72 hours after de ane. than "naturel", or item ne Medical Exerni arr	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 24 If Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐KNo		Rican, etc.)	Specify	k, White,	
Maryland 21215-0036	72 hou	ted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ina	16b, Kind of Bu	ısiness/In	ndustry
121	ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retired Homemake		9	Own	Uom	
42	Hygia Hygia Int.	CO	17. Father's Name (First, Middle, Last)	<u> </u>		Homemake	18. Mother's Name	e (First, Middle,			e
an		To Be	George Karageo	rge			Ethe1	Karag	eorge		
ary	shou and M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a	and Number or Rura	al Route Number	r, City or Town,	State, Zip	Code)
	and 2 eaith m 27 i		Michael Lakis -	Husban							, MD21224
Baltimore,	permit. Peges 1 and 2 should by Deperment or Health and Menta Important: if Item 27 is marked eny injury or other traumatic engine.		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.	y)	St. Dem	etrios	3-14	-07	Baltin	ore	, MD
Bal	Depermit Impor eny in		21. Signature of Funeral Service Licer	- Julas	P	A, 2134	Willow	Spring	Rd, 2	Fun 2122	eral Home 2
ı	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.							or respiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	tastaho	colon co	ancer				Sept 2006
1	Examiner			Due to (or as	s a consequence of):						
9	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of):						
(I)	ecuter end -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequence of):						
68760,	icate be executed physicien end s the burial-transit	edical E		d	a consequence or,						
	entifica ding pt	/Med	IF FEMALE:	220 If you not come	of programme		<u>, -, - , - , - , - , - , - , - , - , - </u>				100000000000000000000000000000000000000
O. Box	requires that the death certificate be executed been signed by the attending physicien end hould be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat Mo	e of deliventh	ery Day Year
٥,	es that the igned by be detact	by Pr	Part II. Other significant conditions of	ontributing to death t	but not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contr	ribute to t	he cause of death?
rds	w require been sig should b	ed t						1 🗆 Y	es 2 No	3 Proi	bably 4 Unknown
Division of Vital Records, P.O.	The law rate hes be page 2 sh	Completed						24a. Was a autops perform	sy p maegt? c	Were auto prior to co death?	opsy findings available impletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death				
to	Phys r this oral dir	٠. ٦	1 ☐ Yes 2 No 27. Magner of Death	28a. Date of Inju	ient 2 ER/Outpatie		4 Nursing no	me 5 Residence 128d. Describe he			(v)
Ö	Attending Independent of the color. After by the funer	atlor	Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year) Injury	Work	k? Yes 2 □ No		,	-	
Divis	ne Hospital or Attendin n 24 hours eltar death. ne Funeral Director: Al	Certification;	3 Suicide 6 Could not b determined	28e. Place of in	ijury - At home, farm, s	reet, factory, office		28f. Location (S City or Town	treet and Numb n, State)	er or Aura	al Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medical (29a. Certifier 1 Cartifying Ph (Check only one) 2 Madical Exar	ysician: To the best niner: On the basis of and manner si	t of my knowledge, dea of examination and/or it tated.	th occurred at the time	ne, date and place, pinion, death occurr	and due to the cred at the time, d	ause(s) and ma date and place, a	inner as s and due t	stated. o the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier			29c. License		1	29d. Date signed		
			Nazaven	<u>·</u>		DS3	V +U		rriard	13,	2007
100	8		30. Name and address of person who	Hupita	11 1650	Dr/KGUS	- 5 x 8	alt, m	D 212	3/	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6	32. Regist	trar's Signature	beech					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fh 2865 3-16-07 vt. State of Maryland / Department of Health and Mental Hygiene?

2. Date of Death Month

1 - For State Registrar Certificate of Death

1

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2 □ No

18:42 PM

Year

itizen of What Country?

N/A

	/Medi		LEON		LE	MON	March	12	2007
	Examir		4a. Facility Name (If not institution, gir	A		4b. City, Town, or Location of Dea	th	4c. Cou	inty of Death
			Sinai Hospital	of Baltimore		Baltimore (ita		NI
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Under 24 Hrs		th	9. Birth
	Director		212-44-35/9	1XM 2□F	Yrs.	Months Days Hours Min	AUG 2	y Year	Coy
			Usual Residence of Decedent				140,9	0,1779	0 1-11
_	land W		10a. State 10b. County	10c. Cit	y, Town or Loc	cation			
5	Maryland -f show	5	ALADULIA I	11/2		BALTI	1005	1 -	,
3		ct	MAKYLAND /	VIA			YORE .	CITY	
emon	with the a or 28a Lba nottl	3	10e. Street and Number	Rosalind		10f. Zip Code		10g. Citizen	of What Cou
Ú	th w	a	3015 KK	FALLYN AVEN	JUE	0/2	15		1151
_	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hispanic Origin? (pecify Yes or No		Race · Ameri
Ten	after or its	F	1 Never Married 2 Married	1 XYes 2 No		Yes, specify Cuban, Mexican, Puel	to Rican, etc.)		Black, White,
5	S	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	Yes 2 No Specify:		Spe	ecity: 13
ن	5-0036 72 hours att	ed	15. Decedent's E	ducation	16a, Deced	ent's Usual Occupation		16h Kind o	of Business/In
A 3	215-	Completed	(Specify only highest gr	ade completed)	(Give)	kind of work done during most of wo OO NOT use retired)	rking	TOD. KING C	i Dusiliosarii
S	Ind 21218 be filed within 7 ital Hygiene. id other then "r event, the Wed	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)		· comp		Hal	1061
6	Hygie D	ပိ	12 HIGRADE			ANITOR		1102	DAY
5	and d be file ental Hy ced oth	Be	17. Father's Name (First, Middle, Last			18. Mother's Na	me (First, Middle	, Maiden Sun	na <i>me) </i>
3	B S S S	၉	JAMES	LE	EMON	1 COR	RINE	(JAM
Che wo	laryla 2 should and Men is marke		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street and Number or R	ural Route Numb	er, City or To	wn, State, Zij
5	Nd 2		ANNIE MITCH	FIL (SISTER)	(301	5 RASALINA	AVE /	301 17	MA
i	Te,		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of	Date	20c. Location	on - City or T
4	O September 1		1 Sorial 2 ☐ Cremation 3			atory or other place)		2 1	
1	tine tant		4 □ Donation 5 □ Other (Speci				20-01	0011	
5	Baltimore, Dermit. Pages 1 e Department of Hes mportant: if them nny injury or othe		21 Signature of Funeral Service Lice	nsee	22.	Name and Address of Facility	BROWN	JR.	FUNE
70	m gg = 9		hequeleas	D 6 11000	20	2140 N. FUL	TONAY	E. BA	12 TO. A
			23a Par 1. Enter the disease, or con	plications that caused the death	n. Do not ente				
_			strock, or freart failure. List only Immediate Cause (Final	and the second second				•	
	Physician /Medical		disease or condition resulting in death)	a Athroscle	rotec	coronary va	sular	duse	ase
	Examiner			Due to (or as a consequence	uence of):	}			
	Examine:		Sequentially list conditions	b					
	70 25	nei	Sequentially list conditions, if any, reading to with ediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uanca of):				
	.O. Box 68760, yethe death certificate be executed the ettending physicien and chedior use as the burial-transit	Examiner	Cause (Disease or injury that initiated events	C					
V	execu n and ial-tra	Ä	resulting in death) Last	Due to (or as a consequ	uence of):				
	Box 68760, ^c sath certificate be exe ettending physicien a for use as the burial-			_					
	5876 icate be physicii s the bu	nysician/Medicai		_ d.					
	Box 61 eath certific ettending p	₩.	IF FEMALE:	220 Huga autom at access					
	ttence at o	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			Date of deliv
	the dear	20	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify)			Month
	0 6		9 Unknown	3G OTIKITOWN					
	HECOrds, P.O. I The law requires that the de	by P	Part II. Other significant conditions	contributing to death but not resi	ulting in the un	derlying cause given in Part I.	23e. Did t	obacco use c	ontribute to t
	ds uire uire d b						10	Yes 2□No	o 3 ☐ Prot
	COLC w requir been si should	ete					-		
	Hec e law has l	ď					24a. Was autop	osv	b. Were auto prior to co
	The The page	Completed					perfo	rmed? 2 No	death? 1 ☐ Yes
	Of Vital F Physicien: Th this certificete ral director, pag	Be C	25. Was case referred to medical			26. Place of De	ath Check only o		
	ysician ysician is certifi director	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ER/Outpatient	O#	fome 5 □ Resid	-	Oth (C
	Phys rathis	-	27. Manner of Death		28b. Time of	3 UOA 4 Nursing P	28d. Describe		
	ding l	0	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work?	200. 0030.100	iow injury oc	,411.64
	Signation of the control of the cont	cat	2 Accident investigation 3 Suicide 6 Could not be			M 1 □Yes 2 □No			
	DIVISION Of VITAI RECORDS, to a Attending Physicien: The law requires teller cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be	₹	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	et, factory, office	28f. Location (S City or Tox	Street and Nu vn, State)	mber or Rura
	o set o	Certification:							
	DIVISION To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Atten-		29a. Certifier 1 Certifying Pl	nysician: To the best of my kno	wledge, death	occurred at the time, date and place	and dua to the	cause(s) and	mainer as s
	Hc 24 Fu	Medical	(Check only 2 Medical Examone)	miner: On the basis of examinal and manner stated.	tion and/or invi	estigation, in my opinion, death occi-	rred at the time,	date and place	e, and due t
	ithin o th omp	Me	29b. Signature and title of certifier	0		29c. License number		29d. Date sig	ned (Month.
	r ≯⊢ŏ	- 2	n//// ///	1		1 1 -22	7-/	,	A

1. Decedent's Name (First, Middle, Last)

ied 2 Married 4 Divorced	Amed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☒No Specify:	specify Yes or No- to Rican, etc.)	Black, White, etc. Specify: BLACK
15. Decedent's Educify only highest grad	ucation 16 de completed)	Give kind of work done during most of work life. DO NOT use retired)	rking 16b.	Kind of Business/Industry
ADF	College (1-4or 5+)	Iffe. DO NOT use retired)	H	OLIDAY INN
(First, Middle, Last)		18. Mother's Nar	me (First, Middle, Maide	n Sumame)
ES	LEN	YON CORI	RINE	JAMISON
ame/Relationship (T)	ype, Print) 19	9b. Mailing Address (Street and Number or Ru	ural Route Number, City	or Town, State, Zip Code)
MITCHE	LL (SISTER)	3015 RASALIND	AVE BAL	TO. MD 21215
position	20b. Place	of Disposition (Name of	Date / 20c.	Location - City or Town, State
☐ Cremation 3 ☐I 5 ☐ Other (Specify)	nemoval irom State	ery, crematory or other place)	20 22 00	J. Joe Wille MA
neral Service Licens	- Lypry	RRISON FOREST 03-		INGS MILLS MA
illeral 38 Dec Licens	t Rosac			R. FUNERAL HOME
Mexal	PITT	2140 N. FUL		BALTO, MD 21217
he disease, or comp rt failure. List only o (Final in	lications that caused the death. Do not cause on each line. a	onot enter the mode of dying, such as cardiac otto coronary va e of):		Approximate Interval Between Onset and Death
nditions, include trying injury	b. Due to (or as a consequence	o of):	-	
Last	Due to (or as a consequence	9 of):		
t pregnant months?] No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deal 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
icant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I.	23a. Did tobacco	use contribute to the cause of death?
			1 □ Yes	
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
red to medical		26. Place of Dea	ath Check only one)	
No 1	Hospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA Other: 4 Nursing H	fome 5 Residence	6 □Other (Specify)
h 5 🗆 Pending investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury at Work? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe how inju	ury occurred
6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, re)
1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledginer: On the basis of examination a and manner stated.	go doeth occurred at the time, date and place and/or investigation, in my opinion, death occu	and dua to the daune(s arred at the time, date ar	e) and manner as stated. Id place, and due to the cause(s)
title of certifier		29c. License number	1 - /	ate signed (Month, Day, Year) NCA 12, 2007

21215

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

M.D. 2401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MAHATABIW S. ALI, M.D., 2401 West

ORIGINAL

West Belvedue tve, Baltimore

6:55 р.т. Baltimore, Maryland 21215-0036 MARCH 12, 2007

Division or Vital Records, P.O. Box 68760, FREDERICK JAMES LADD

		For	State of Ma	ryland /	•			Mental Hy	giene		
		State Registrar			Cer	tificate of L	Death		Reg. No.	1117	18307
Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of D	eath Day	Year	3. Time of Death
/Medic		FREDERICK		LADD				March		007	6:55 P. [™]
Examin	er	4a. Facility Name (If not institution,	•			4b. City, Town, or		1		ty of Death	
		Stella Maris Ho 5. Social Security Number		e (In yrs. last	birthday)	Timoniu	JM If Under 24 Hrs.	8. Date of Bi	rth	1timo	place (State or Foreign
Funeral Director		278-46-4186		81	Yrs.	Months Days	Hours Min.	Feb. 12	i, Year)	Coui	and
p _		Usual Residence of Decedent		10.00							
arylar show d at	7	10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits 1 ☐ Yes 2 No
he M	Director	Maryland Balti 10e. Street and Number	more	Tow	rson	10f. Zip Code			10g. Citizen of	1M/h at Cau	
with i			D = d				01.007		rog. Cilizen of	What Coul	nuy?
ns 23 mus	Funeral	500 Worcester 1	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	21286 spanic Origin? (S	pecify Yes or N	o- 14. Ra	ce - Americ	can Indian,
after o		1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 ☑ N If Yes, Give	lo		Yes, specify Cubar ☐ Yes 2X No		to Rican, etc.)		ack, White,	etc.
ours a	d by	3 Widowed 4 Divorced	Year or Dates:			Lites ZALINO	Specify:		Speci	ify: Whi	.te
72 h "natu dical	Completed	15. Decedent's (Specify only highest	Education grade completed)	16	6a. Deced <i>(Give L</i>	ent's Usual Occupa kind of work done d O NOT use retired)	ition uring most of wor	rking	16b. Kind of E	3usiness/In	dustry
within ene. than	Ē	Elementary/Secondary (0-12)	College (1-4or 5						FA	lucati	on
filed Hygi other		17. Father's Name (First, Middle, La	5+ year	S	ALL I	History P	18. Mother's Nar				OH
ld be ental ked o	To Be	Albert Ladd					Grace I	Brush			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notifled at	-	19a, Informant's Name/Relationship	p (Type. Print)	1	9b. Mailing	g Address (Street a	nd Number or Ru	ıral Route Numi	per, City or Town	າ, State, Ziຸ	Code)
and 2 ealth a m 27 is		David Lindenstru	ith (Per.	Rep) 3	31 Ce	dar Ave.	Towson	, Maryl	and_2128	36	
of He of He or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	3 □Removal from State	20b. Place ceme	of Dispos etery, crem	sition (Name of natory or other place	e) :	Date	20c. Location	- City or To	own, State
Pages Iment of Hant: If ite	-	4 Donation 5 ☐ Other (Spe	ecify)	Gree		unt Crema		-14-07			Maryland_
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service/Li	censer / Eno	ekis	, 22 M	Name and Addres itchell-V 6500 York	s of Facility Viedefel C Road	d Funer Baltimo	al Home re, Mary	, Inc yland	·21212
		23a. Part1. Enter the disease or c shock, or heart failure. List of	omplications that caused nly one cause on each lin	the death. D	o not ente	er the mode of dying	g, such as cardia	or respiratory	arrest,		Approximate Interval Between
Physician	Ϊ	Immediate Cause (Final disease or condition	_a LEUKEMIA								Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	a consequenc	ce of):	-					
	e	Sequentially list conditions,	b. Due to (or as a	a consequenc	ce of):					-	
uted Insit	Ë	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)			,						
execting and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a	a consequenc	ce of):						
icate be executed physician and s the burial-transit	dical	•	d								
ertifica ing ph	w	IF FEMALE:	1								
ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 🗌 Fetal dea	ath 3□	Ectopic pregnancy			I	ate of deliv	ery Day Year
the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown	time of death	1 5∐	Other (specify)					,
that the by detail		Part II. Other significant condition	is contributing to death bu	ıt not resulting	g in the un	derlying cause give	n in Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
quires n sigr ald be	d by							10	Yes 2 No	3 ☐ Proi	babiy 4 x]Unknown
aw rei s bee	Completed							24a. Was			ppsy findings available
The late ha	mo:							auto perf 1∐ Yes	ormed? 2 X No	prior to co death? 1 ☐ Yes	mpletion of cause of
slan: ertifica ctor, l	Be C	25. Was case referred to medical examiner?					26. Place of Dea				
hysic this co	10	1 Yes 2 No	Hospital: 1 Inpatie		Outpatient		4 LI Nursing F	T	idence 6 X Ot		HOSPICE
ling F After funera	iuo iii	27. Manner of Death 1 ▼ Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28t	b. Time of Injury	28c. Injury Work		28d. Describe	how injury occu	rred	
death ctor: / the f	icat	2 Accident investiga 3 Suicide 6 Could no	ot be 280 Place of inju	Inv - At home	farm stre		′es 2 □ No	28f Location	(Street and Num	ther or Rur	al Route Number,
lor A after Direct	Certification:	4 ☐ Homicide determin	building, etc		iain, oro	ot, idotoly, othor			wn, State)	ber or riura	arrioute Number,
To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tim restigation, in my op	e, date and place pinion, death occi	e, and due to the urred at the time	e cause(s) and n	nanner as s	stated. o the cause(s)
To the To the To the Complex c	Me	29b. Signature and title of certifier)			29c. License	number		29d. Date sign	ed (Month,	Day, Year)
-)	2			Dh	3725		31	1316	7
11		30. Name and address of person w	ho completed cause of de	eath (Item 23a	a) (Type, F	Print)			/	-10	
11		DR. TARIQ MAHM 31. Date filed (Month, Day, Year)		ULANEY ar's Signature		EY RD.	<u> TIMONIUM</u>	, MD 21	093		
Sta Registr		MAR 1 6	2007	er signature	1	mark 8					
		MARIL	LUUI JURANA		11/1/1						

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07-01838	
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Shantele Patrice	•		of Maryland			h and Mental	Hygiene	200	7 0000
		- For State Registrar		Certifica	te of Deatl	1		g. No	
Physicia		1. Decedent's Name (First, Middle,La	st)		1		Date of Death Month	n Day Year	3. Time of Death
Medical Examin	er	ShANTele	PATE	ic c	Lyne	h	March 8, 2	007	1304 hrs
		4a. Facility Name (if not institution, g	ve street and number)	1 "	own, or Location of De	ath	4c. County of Deat	
		1901 Sulphur Spring Roa	d		Lanso			Baltimore Co	
Funeral	T	5. Social Security Number 6. S	Sex 7. As	ge (In yrs. last birth		r 1 Year If Under 24	_	n(MM/DD/YYYY) 9. Bi Forei	
Director		219.04-7779 1	M 2/2F	37	Yrs. Months	Days Hours N	MAY2	8,1966 0	ountry) MA
	Ė	Usual Residence of Decedent							I do la la la constituente
/ any		10a. State 10b. County		10c. City, Town o					10d. Inside City Limits 1 Yes 2 No
nd show	Ӹ	mD M	A	B	4 /T/MC	re			7
laryla	Director	10e. Street and Number			10f. Zip	Code	10	g. Citizen of What Co	intry?
ith the Maryland 23a or 28a-f show notified at once.	吉	3705 Cople	(Pd			21215		21.5. A	
with	ᅙ	11. Marital Status	12. Was Deceden			nt of Hispanic Origin?		14. Race - Ame White, etc.	rican Indian, Black,
leath r iten	Funeral	1 Never Married 2 Marrie	Armed Forces	? 2 No	if Yes, specif	y Cuban, Mexican, Pue	erto Ricari, etc.)	VVIIILE, ELC.	12 6
fter de I", or	- 1	3 Widowed 4 Divorce	ed If Yes, Give Year	~	1 Yes 2	No specify:		Specify: 9/	HER
nurs a ntura	a P	15. Decedent's Education (Specify	only highest grade co		_	Occupation (Give kind king life. DO NOT use	C	16b. Kind of Business	· · ·
72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	idiling filost of wor	King life. DO 1401 ase	retired)	Pattina	In format.
036 tthin ne.	副	12 ugrade	None	<u> </u>	ATA F	ROCESSON	<u> </u>	INTO Cd	nputers
5-0 led w tygie othe		17. Father's Name (First, Middle, Las	st)			18.Mother's Na	ame (First, Middle, M	laiden Surname)	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	a	VIRGII LY	neh			GIA	yne.	1)AV15	7: 0-4-)
AD 21 2 should h and Mer 27 is man imatic ev	ဥ	19a. Informa s Name/Relati ship	(Type, Print)			(Street and Number		ber, City or Town, Sta	
MD d 2 sho lith and n 27 is		Virgil LUNI	ih		3705	Copley	Date D	20c. Location - City of	r Town State
Featrant Featrant	Ì	20a. Method of Disposition 1 Burial 2 Cremation	Removal from S		f Disposition (Nar ory or other place)	ne of cametary,	Date	200. Education - Oity o	i town, State
MOFE Pages I ent of F int: If		4 Donation 5 Other Speci		King	Memor	iAl PK 1	1AR.14,200	KANDA/1	Town mis.
Baltimore, permit. Pages I at Department of Hei Important: If ite	ı	21. Sig tur of Funeral Service Lic		- 1	22. Name and	Address of Facility	Il has m	0.	
E P P P F F F F F F F F F F F F F F F F	- }	Anthine S	Bitte		112	gn. Chec	line ST	- BAITO.	
Physician		23a. Part I. Enter the disease, or con	nplications that cause	ed the death. Do no	t enter the mode	of dying, such as cardia	ac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical	ļ	failure. List only one cause on Immediate Cause (Final disease	_{a.} Contact Gunsl	not Wound of I	Head				Death
Examiner		or condition resulting in death)	Due to (or as a con						
	- 1	Sequentially list conditions,	b						
	ē	if any, leading to immediate	Due to (or as a con	sequence of):					
_	Examine	(Disease or injury that initiated	c. Due to (or as a con	sequence of):					
red		events resulting in death) Last	d						
xecuted n and l - transit	cal	UNPENDED	AMENDED						
O, e be e ysicia buria	edi			ome of pregnancy				23d. Date of delive	ery
376 ificat ig ph	N/	IF FEMALE: 23b. Was decedent pregnant in the	1 Live birth	ome or pregnancy	Fetal death	3 Ectopic pre	egnancy	Month	Day Year
K 68	cia	past 12 months?	7	at time of death		ecify)		21	
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medi	1 Yes 2 No 9 V Unkno	3 _ Sindio				1 = 2 = 1		to the sauge of dooth?
Records, P.O. Box 68760, The law requires that the death certificate be executed rate has been signed by the attending physician and large 2 should be detached for use as the burial - trans		Part II. Other significant condition	s contributing to de	ath but not resultin	g in the underlyin	g cause given in Part I.		obacco use contribute	robably 4 Unknown
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ds requir	ete	F					24a, Was autor		autopsy findings available completion of cause of
COT law las l	ηp							rmed? death	
Re The ficate	Completed					26.Place of Death (Ch		2	
certi:	Be	25. Was case referred to medical examiner?	Hospital:	atient 2 ER/O	utpatient 3			Residence 6 🗸 Ot	ner: Scene
Physical Circles	2	1 Yes 2 No	28a. Date of I		Time of Injury	28c. Injury at Work?	•	how injury occurred	
Ing I		27. Manner of Death 1 Natural 5 Pendin	L CONNIN Da		JND:	1 Yes 2 ✓ No	Subject sho	ot self	
ttend death stor:	atic	2 Accident Investig	Mar 8, 200	7 125	5 hrs			Street and Number or	Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial-	Certification:	3 V Suicide 6 Could	not be			y, office building, etc.	or Town	State) r Spring Road, Lans	
Di pital ours a	Sen	4 Homicide determ	(40,-0)	n a parking lot			10 211		
Hos 24 ho Fun		(Oncon any)	sician: To the best of	f my knowledge, de	ath occurred at the	ne time, date and place	, and due to the cau red at the time date	se(s) and manner as s and place, and due to	ialeu. hthe cause(s)
o the Athin o the comple	Medical		ner:On the basis of e and manner state	ed.				29d. Date signed (
F × F 5	Ž	29b. Signature and title of certifier			25	C. C. N. F.			nomi, boy, rour
		My w,	m.D			O.C.M.E.		March 9, 2007	
		30. Name and address of person w	ho completed cause of	of death (Item 23a)					
4		Ling Li, MD Assistan	Medical Exami	ner 111 Per	in Street, Bal	timore, MD 21201	1		

Registrar's Signature

ORIGINAL

State Registrar

Ellsworth	Н.	Merson,	Jr.	
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State of Manyland / Department of Health and Mental Hygiene

ensworth H. Mer		1- For State Registrar	State of Marylar	•	ificate of		u Mentai i	Re	g. No. 200	17 0830
Physicia Medical Examir		1. Decedent's Name (First, Min Ellsworth $H_{\:\raisebox{1pt}{\text{\circle*{1.5}}}}$						2. Date of Death Month February 2		3. Time of Death 1540 hrs
)		4a. Facility Name (if not institu	ition, give street and num	ber)	4	b. City, Town, or Edgewood	Location of Dea		4c. County of Dea	ath
Funeral		Social Security Number	6. Sex 7	. Age (In yrs. las	st birthday)	If Under 1 Yea			h(MM/DD/YYYY) 9. E	
Director		213-76-9417	1XM 2F	44	Yrs.	Months Day	s Hours M	Feb 20	, 1963	Country)Maryland
any	ŀ	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, T	own or Locati	on				10d. Inside City Limits
laryland :8a-f show at once.	ģ	MD Han	rford	Ed	lgewood	10f. Zip Code		110	g. Citizen of What Co	1 Yes 2 X No
th the Mar 23a or 28s notified at	Director	1953 Sindee I	Orive			101. 2ip 00de	210		US	-
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Menfal Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumarie event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2	Married Armed Ford			s Decedent of His es, specify Cubar		Specify Yes or No- rto Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,
after de	by Fu	3 Widowed 4 I	1 Yes Divorced If Yes, Give Year or Dates:	2 <u>X</u> No	1	Yes 2 X No	specify:		Specify: w	nite
2 hours "natur	ted	15. Decedent's Education (S Elementary/Secondary (0-1		,		is Usual Occupatost of working life			16b. Kind of Busines	s/Industry
0036 within 72 jene her than Medical	Completed	12	0		main	tenance			refridge	eration
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Co	17. Father's Name (First, Midd $E11sworth\ H$						me (First, Middle, M Kerper	faiden Surname)	
2121 should be find Mental is marked atic event,	일	19a. Informant's Name/Relation					et and Number o	or Rural Route Num	ber, City or Town, Sta	
re, MD 21215 1 and 2 should be file Health and Mental H Fitem 27 is marked or traumatic event, the	-	20a. Method of Disposition			ace of Dispos	ition (Name of ce		Date Date	imore, MD 20c. Location - City	21234 or Town, State
Baltimore, permit Pages I an Department of Hea Important: If itel		Burial 2 Cremaid Donation 5 X Other	Specify: in sta	te	ematory or oth	ier place)				
Baltimore permit Pages 1 Department of F Important: If i		21. Signat of Funeral ry RO 1 d	ice Licensee	irector	22 N St 8	ame and Address ite Anat timore,	of Facility Omy Boa MD 21	rd 655 W.	Baltimor	e Street
Physician		23a Part I. Enter the disease failure. List only one cau	or complications that cause on each line.	used the death. [Do not enter the	ne mode of dying,	such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
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cuted and transit	al Exa	events resulting in death) La	st Due to (or as a c	onsequence or)		-	_			
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fox 68760, eath certificate be executed e attending physician and for use as the burial - transi	ian/M	IF FEMALE: 23b. Was decedent pregnant i past 12 months?	n the 1 Live bir		2 Fe	tal death 3	Ectopic pres	gnancy	Month	Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/	1 Yes 2 No 9	Unknown 9 Unknow		^{ttn} 5 Ot	her (Specify)				
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rds, I requires been sig		-						24a. Was a		autopsy findings available o completion of cause of
Recol	Completed							perfor	med? death	?
ician: ician: s certific	Be	25. Was case referred to med examiner?	Title amitati	patient 2 I	ER/Outpatient		e of Death (Che		Residence 6 ✓ Ot	her: Scene
of V ng Phys After thi	n: To	1 Yes 2 No 27. Manner of Death	28a. Date o	'	28b. Time of I	njury 28c. Inju	ury at Work?		now injury occurred	
Sion Attendi r death. ector: A	Certification:	2 Accident	rvestigation 28e Place		me farm stre	et, factory, office	Yes 2 No	28f. Location (S	Street and Number or	Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	ertifi		Could not be letermined (Specify)					or Town, S		
he Hosp in 24 hc he Fune pletely f		29a. Certifier (Check only one) 2 Medical I	g Physician: To the best Examiner: On the basis of	of my knowledg f examination an	e, death occui nd/or investiga	rred at the time, o tion, in my opinio	date and place, and place, a	and due to the caus ed at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
To the within To the comple	Medical	29b. Signature and title of ce	and manner sta			29c. Licen			29d. Date signed (Month, Day, Year)
		Theoden l	1. King Ji	quel	2	0.0	.M.E.		February 27, 2	007
		30. Name and address of per Theodore M. King,		e of death (Item: nt Medical E		111 Penn S	treet, Baltim	ore, MD 21201	1	
Si	ate	31. Date filed (Month, Day, Ye	ear) 32 Reg	gistrar's Signatur	re	3				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year 2007 March 13, 1:50 pm Genevieve Tnez Mohr 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Middle River
If Under 1 Year If Under 24 Hrs. Baltimore Ivy Hall Geriatric Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours Min 1□M 2**X**F Yrs. 12/10/1920 214-22-4118 86 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6 Capri Drive 21221 Α. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 ☐Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 Owner / Operator Hair Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Abrose Yeatman Marian Alice LeBrun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12126 Buttonwood Lane Middle River, Maryland 21220 (Nephew) Rich Gale 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 3/15 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2007 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Luchar 1 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 120ten Due to (or as a consequence of) zasele Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to to, as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical Examiner

Examine

Physician/Medicai

ð

Completed

Be

Certification: To

Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lijury or other traumatic event any lijury or other traumatic event angle.

Physician

/Medical

Examiner

Funeral

Director

•how

the Medical Examiner must be notified at

or iteme 23a or

a filed within 72 hours after il Hygiene.
other than "netural", or ite

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

N3 burial-transit and Division of Vital Records, P.O. Box 68760,

ete hes been signed by the attending physicien page 2 should be detached for use as the buria el or Attending Physician: T s atter death. si Director: After this certificet ed in by the funeral director, ps

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed? Yes 2 XNo 1 Yes

26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

25. Was case referred to medical examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ANatural

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred

Stante 308

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

BACTIMOSEMI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOALB A HASHM / MI), 821 N NENTAN

31. Date filed (Month, Day, Year) State Registrar 6 2007

2 Accident

3 Suicide

4 Homicide

32. Registrar's Signature

To the Hospitei 24 hours a

within 24 hou To the Fune completely fi

		1	For State Registrar	State of Ma			nt of He <i>te of E</i>			jiene2 () () () leg. No.	08311	
	88		Decedent's Name (First, Middle, Last	t)			-		2. Date of Dea	th	3. Time of Death	
	Physicia		Gerald Eugene	Mundth					Month March	11, 2007 Year	10:10 P ^M	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City	, Town, or	Location of Death		4c. County of Dea		
	LXaIIIII	şı	Hart Heritage			St	reet			Harford		
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Und	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bi	rthplace (State or Foreign	
	Director		399-16-9672	© M 2□F	79 Yrs.	Months	Days	riguis Iviii.		, 1927 Wi		
	p .		Usual Residence of Decedent		10c. City, Town or Lo	antion					10d. Inside City Limits	
	anyla •hov	_	10a. State 10b. County		Toc. City, Town of Ec	oation					1 ☐ Yes 2 ☑ No	
	Ba-f	Director	Maryland Harford		Bel Air	101.7	in Code			10g. Citizen of What C	Country?	
	with t	吉	10e. Street and Number				ip Code				ourity:	
	72 hours after death with the Maryland natural; or terna 23a or 28a-f ehow disul Faard af must te collined at	Funerai	209 Duncannon R	Dad 12. Was Decedent E	ver in II S 13		21014	spanic Origin? (Sp	ecity Yes or No-	USA 14. Race - Am	erican Indian.	
	Item Item	Š	1 Never Married 2 Married	Armed Forces?		II Yes, sp	ecify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Wh		
336	urs af	þ	3 Widowed 4 Divorced	ty⊡Yes 2 ☐ No If Yes, Give Year or Dates:		1 🗆 Yes	3 € No	Specify:		Specify:	White	
21215-0036	2 hou	ed led	15. Decedent's Ed	lucation	16a. Dece	dent's Us	ual Occupa	tion	via a	16b. Kind of Busines		
215	within 7 ene. than "n	Completed	(Specify only highest gra	College (1-4or 5+	life.	DO NOT	use retired)	uring most of wor	(III)			
21	giene grant ar thu	No.	, , , , , , ,	4		or c	f Pla				Manufacture	
pu	al Hy al Hy f oth	Be	17. Father's Name (First, Middle, Last,					18. Mother's Nam	e (First, Middle,	Maiden Sumame)		
Ja	Ment Ment mrke atic	卢	Frank Lyman Mu	ndth				Vesta	Mae Pov	vell		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Health and Mental Hygiene them 23e or 28e-f show Item 27 Ie marked other than "natural", or Itema 23e or 28e-f show other traumatic event, the Medical Exertil or marker colline and		19a. Informant's Name/Relationship (Type, Print)	1		•			r, City or Town, State,	Zip Code)	
	of Health of Health (Item 27 I		Jeff Mundth / So	n				e Road,	Bel Air,	MD 21015	Town Chata	
Baltimore,	ges 1 t of H If Ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre	matory of	other place	9)	Date	20c. Location - City of	r rown, State	
Ē	permit. Pages. Department of Important: If Ite any injury or of	1	4 Donation 5 Dother (Specify) EntombmentBel Air Memorial Grdn 3-16-07 Bel Air.									
3all	permit Depari Impor any in		21. Signature of Euneral Service Licer	See /				héfál Ho			2011	
	4 □ = 4 0		Alfle (11.1	Leegy						don, Mary		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	the death. Do not en e.	ter the m	ode of dying	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	a. END	STAGE	ire	Men	F. A			~ 19201	
7	/Medical Examiner		resulting in death)	Due to (or as a	consequence ol):							
	ZAGIIIII	_	Sequentially list conditions,	b. Due to (or as a	consequence of):							
	ed isit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 43 4	consequence on.							
	xecul and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence of):							
8760,	ate be executed hysicien and the burial-transit	dical E		d								
687	ate y d	ed o		. d								
Box (eath certific attending pl	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Date of d	elivery	
ă	death a atte d for	cia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at t		⊒Ectopic ⊒Other (pregnancy specify)			Month	Day Year	
P.O.	by th	hys	9 Unknown	9□ Unknown								
	w requires thet the been signed by th should be detache	Y P	Part II. Other significant conditions	ontributing to death bu	I not resulting in the u	ınderlying	cause give	n in Part I.	23e. Did to	bacco use contribute	to lhe cause of death?	
ğ	quire on sig uld b	be							1 🗆 Y	'es 2□No 3□	Probably 4 Onknown	
00		Completed							24a. Was	an 24b. Were	autopsy findings available completion of cause of	
Re	The law ate has b page 2 s	E	autopsy performed? death? 1 □ Yes 2 ☑ No 1 □ Yes 2 □ No									
tal		0	25. Was case referred to medical					26. Place of Dea	th (Check only o		Assisted	
<u>></u>	9 U =	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier	nt 2 ER/Outpatie	nt 3 🗆 I	OOA Othe	9r: 4 🗆 Nursing H	ome 5 Resid	lence 6 Other (St	pecity) CARL	
Division of Vital Records,	ding Phys h. After this funeral di	ü	27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time o	of	28c. Injury Work	at	28d. Describe h	now injury occurred	FACILITY	
Ö	Attending r death. ector: After by the fune	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	, , , , , ,	М		res 2 □No				
Vis	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, larm, st . (Specify)	reet, fact	ory, office		281. Location (5 City or Tox	Street and Number or i	Rural Route Number,	
	ital or irs afte ral Dir led in	Certification:										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical	(Check only 2 Medical Example 1997)	nysician: To the best on the basis of	examination and/or in							
	To the h within 24 To the F complete	Medi	one)	and manner stat	ted.							
	J. S. D. D. D. D. D. D. D. D. D. D. D. D. D.	-	29b. Signature and title of certifier	Mc Ma		1	J. Cicerise	28889		MADEL	7, 7.002	
	X		0. 17-1	100			2	7007		1-114/100	-,	
1	L		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)	ALP	HD: 1	Bel 1.	NMA	2/0/4	
1		٠	31. Date filed (Month, Day, Year)	32 Registra	r's Signature		, -,		1 74 1		nth, Day, Year) 12, 2007 21014	
	Sta Regist		MAD 1 6 20	107	M Ra	and I						

State of Maryland / Department of Health and Mental Hygiene / [11] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** March 13, 2007 8:50 PM Betty Lou Miller /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2852 Beckon Drive Edgewood Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 214-36-9347 Director 69 Feb. 17, 1938 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Harford Maryland Edgewood 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2852 Beckon Drive 21040 23a USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant VA Medical Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Lloyd A. Harris Anna Louise Norton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pagas 1 and 2 Dapartment of Health a Important: if item 27 is eny injury or other trat QDCS. 2852 Backon Drive, Edgewood, MD 21040 of Disposition (Name of Date 20c. Location - City or Town, State Samuel Miller Sr./ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 2ua, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John Wesley U.M. Cem. 3-19-07 Abingdon, Maryland 21. Signature of Funeral Service Licensee 2MCCOMASOFUNETAL Home, P.A. 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTANC Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death cartificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical tha e use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signad by tha at the datachad for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use pribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifice 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death Check only ane 200 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Director: After the 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pragner stated. 29a. Certifier 29b. Signature and title of gertfier 29c. License number 29d. Date signed (Month, Day, Year) MARCH see cause of death (Item 23a) (Type, Print) 2112 BELAR

State Registrar 1. Date filed (Month, Day, Year)

o.

39. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MONTH Year **Physician** 2:25 AM William T. McNamara, Jr. 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samaritan Nursing Center Baltimore N/C 7. Age (In yrs. last birthday)

R 9

Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 8, 1917 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 x M 2 □ F 216-05-7690 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode ! 7 is marked other then "naturel", or items 23s or 28s-f ebov treumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Nottingham Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Delgreen Court 21236 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "ne any injury or other freumatic event, the Mental 2006. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William T. McNamara. Sr. Edith Pearl Eades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifton M. Gonce 4305 Four Mill Road, Nottingham, MD (step-son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 3/17/2007 Parkville, Maryland 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Schimunek Funeral Homes Duis D. 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END ISCHEMIC CARDIOMYOPATHY STAGE **Physician** /Medical Due to (or as a consequence of): Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physicien and s the burial-transit Due to (or as a consequence of): Completed by Physician/Medical use as attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) o. sete has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, PNEUMONIA 3 ☐ Probably 4 ☑Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ✓ ✓ ✓ ✓ 24a. Was an autopsy performed? 1 Yes 2 🛂 No : After this certifical funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 Natural after death.
I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Atribeh, Ms 10061789 MARCH, 12, 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOPPA (NE OFFILAWUAH, 9106 PHILADELPHIA PD, STE 208, BALTIMORE, MD 21237 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Conti Registrar

DHMH 17 Rev 1/2001

NAWARA

ORIGINAL

	1 _ State	nd / Department of Health a Certificate of Death		0007 003 11
	Registrar 1. Decedent's Name (First, Middle, Last)	Octimodic of Death	Reg. I	3. Time of Death
Physiciar /Medica			Month	15 2007 5:10 M
Examine	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	f Death	4c. County of Death
	LORIEN & RIVERSIDE 5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday) If Under 1 Year If Under 2		HARFORD
Funeral Director	1X M 2□ F	Months Days Hours	Min. (Month, Day, Yea	
ס	Usual Residence of Decedent		11ay 7, 192	
show		City, Town or Location		10d. Inside City Limits 1 ☐ Yes
with the Ma s or 28a-f s be notified	Maryland Harford Be	1 Air	10a.	Citizen of What Country?
h with		21015		S.A.
at y lidition of L Z I 3-0030 should be filed within 72 hours after death with the Maryland not Mental Hygiene. It marked other then "natural", or Items 23a or 28a-f show unatic event, the Medical Examinational parallel	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of Hispanic Original In Yes, specify Cuban, Mexican		14. Race - American Indian, Black, White, etc.
urs afte	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: White
Phours at Exar		16a. Decedent's Usual Occupation	16b.	. Kind of Business/Industry
ed within 72 ho ygiene. ner then "netur. t. Its Wed call.	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)	of working	,
od will ygjen t, the	2	Tool and Die Maker		etal Packaging
Id be fill be till ked oth	17. Father's Name (First, Middle, Last) David William Narango		r's Name <i>(First, Middle, Maid</i> 2 Ament	len Sumame)
should and Men marke maric	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Numbe		v or Town State Zin Code)
NG 2 salth ar 27 is r trau	Paula Narango (Wife)	500 Cedar Spring H		
es 1 a cof Her rothe		Place of Disposition (Name of cemetery, crematory or other place)		Location - City or Town, State
Page ment ment: It ant: It	TE Bottal 222 Oremation 5 Enternoval from State	yview Crematory 03	3/16/2007 Bal	Ltimore, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any jriury or other traumatic avent, the Medical Examinat must be notified at 2006.	21. Signature of Funeral Service Licensee			neral Home of Bel Ai
40200	23a. Part1. Enter the disease, or complications that caused the dea	Inc. 610 W.Mack		Air, MD. 21014 Approximate
(ALCOHOL)	shock, or heart failure. List only one cause on each line.	ton	sardiac of respiratory arrest,	Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death) a. Due to (or as a conse	udical intantion		
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nat the death certing the death certing the death certing the death certing the death of the dea	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 □ Live birth 2 □ Fel	tal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
the at the at following the	1 Yes 2 No 4 Pregnant at time of 9 Unknown	death 5 Other (specify)		Month Day Year
that the sed by detac	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.	23a. Did tobacc	o use contribute to the cause of death?
quires the signer and be could	Dementia		1 ☐ Yes	2 □ No 3 □ Probably 4 □ Qnknown
aw rex	Chronic Oh tartho Pelm	nous Nistave	24a. Was an	24b. Were autopsy findings available
The law requir			autopsy performed? 1 Yes 2 X	
clan: entific setor,	25. Was case referred to medical examiner?		of Death (Check only one)	
Physical direction	1 ☐ Yes 2 ₹ 2 No Hospital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury		sing Home 5 Residence 28d. Describe how in	
th. After	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of lnjury at Work? M 1 Yes 2 N		jury occurred
tal or Attending P rs after death. el Diractor: Atter ted in by the funera	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At I huilding, etc. (Spec	home, farm, street, factory, office	28f. Location (Street	and Number or Rural Route Number,
rs after sell Direction	building, etc. (Spec	ny)	City or Town, Sta	are)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funarel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examin		nowledge, death occurred at the time, date and attion and/or investigation, in my opinion, death	place, and due to the cause	(s) and manner as stated. and place, and due to the cause(s)
o the lithin 2 o the complet	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
F ≥ F 8	1 Min. Min	n179		3/15/02
3	30. Name and address of person who completed cause of death (Ite	em 23a) (Type, Print)	/ 3	-103/07
2	DAVID Mcchne mn 610	T MacMail Ad /	hel Arr, mr	2. 21014
State Registrar	18 D 1 C 2007 Est	hature had been been been been been been been bee		

			For State	State of Ma	-	Department of F Certificate of			-	21111	08315)
100			Registrar 1. Decedent's Name (First, Middle, La	st)		Certificate of	Deali	2. Date of D	Reg. N eath	Or- 0 0 1	3. Time of Death	_
	Physici			Jane	Oe	echsler		Month March	15.	2007 Year		J
	/Medic Examir		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location			c. County of Dea		_
- A	· · · · · · · · · · · · ·	*	Franklin Woods Nu			Roseda				Balti		
	Funeral Director		214-30-3741	ex 7. Age	(In yrs. last bird	thday) If Under 1 Year Months Days	Hours	Min. 8. Date of Bi (Month, D September	ay, Yea	7) C	rthplace (State or Foreigr country) ryland	7
and	t t		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	n or Location					10d. Inside City Limits	_
Mary	-f sho fied a	tor	Maryland Baltimon	re	Dunc	dalk					1 □ Yes 2⁄□ No	,
th the	or 28g e noti	Director	10e. Street and Number			10f. Zip Code			10g. C	citizen of What C	ountry?	_
ath wi	23a	ral	8006 Wallace Road			2122				USA		
036 urs after de	nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married ¾ Widowed 4 □ Divorced	12. Was Decedent Exarmed Forces? 1 ☐ Yes 2 ☐ X Note that It Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No	an, Mexic	origin? (Specify Yes or Nan, Puerto Rican, etc.) an, Puerto Rican, etc.) Y	0-	14. Race - Am Black, Whi		
5-0 72 hg	natur Jical B	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usual Occup	ation	ost of working	16b. I	Kind of Business	s/Industry	
<u>7</u>	han " e Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		(Give kind of work done life. DO NOT use retire	d)	or working		m Homo		
iled v	Hygie ther t	CO	7 years 17. Father's Name (First, Middle, Last)	l I	Housewife	18. Moth	her's Name (First, Middle		vn Home		
and p	ked o	To Be	William Henry Yea					elyn A. Gib		n comano,		
Maryland 21215-0036	Ifth and M 27 is mar r traumati	-	19a. Informant's Name/Relationship (Elmer Oechsler	Type. Print) Son		Mailing Address (Street Mallace F					00	
or estar	item item		20a. Method of Disposition		20b. Place of	Disposition (Name of	ce)	Date 10	20c. l	Location - City o	r Town, State	
mo Page	ment c		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		Cardens	y, crematory or other pla of Faith Cemet	ery	March 19, 2007	Rose	edale, M	ID.	
Baltimore,	Department of Health a Important: If item 27 is any Injury or other trainonce.		21. Signature of Fun ral Service Licer	e On		22. Name and Addre Connelly F 7110 Solle	uner ers P	al Home Of oint Road,	Dunc Dunc	dalk, P. dalk,MD.	^A . 21222	
9			23a. Part L. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do r	ot enter the mode of dyin	ng, such a	s cardiac or respiratory	arrest,		Approximate Interval Between	
	ysician		Immediate Cause (Final disease or condition	a. Respira	tory Fa	ilure - Aci	.dosi	s			Onset and Death	
	Medical kaminer		resulting in death)	Due to (or as a		of):						
	4	e.	Sequentially list conditions,	b. Severe	consequence of	of):						_
/ onted	ohysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
o , se se se se se se se se se se se se se	an an ırial-tr	Exa	resulting in death) Last	Due to (or as a	consequence o	of):						_
8760, cate be ex	physic the bu	dical		d								
Records, P.O. Box 68760, The law requires that the death certificate be executed	y the attending p ched for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2\tilde{\Delta} No 9 Unknown Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 L							23d. Date of de Month	elivery Day Year	
that	been signed by the should be detached		Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause give	en in Part	I. 23e. Did	tobacco	use contribute t	to the cause of death?	
rds quire	an sigi uld be	ed by	H	ypertension	l .			1数	Yes 2	2	robably 4 ∐Unknown	1
eco law re	has bee ye 2 sho	Completed						24a. Was		24b. Were a	utopsy findings available completion of cause of	,
		mo C						perf 1□ Yes	ormed? 2 X N	death?	.3.7	
Vita ician:	n. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Cuth		ce of Death (Check only				_
OF	r this cral din	2	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 ☐ Inpatient		patient 3 DOA Oth	422 1	lursing Home 5 Res			ecify)	_
On	eath. tor: After th the funeral	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Ir	njury Wor	k? Yes 2 [now inje	ary occurred		
Division or Vital Records, or Attending Physician: The law requires to	after death Director: In by the	Certification:	3 Suicide 6 Could not be determined		y - At home, far (Specify)	m, street, factory, office		28f. Location (Tural Route Number,	
	rs afte al Dir ed in	Cert		building, etc.	(Openy)			Only of 10	wii, Stat	ie)		
Division or Vita To the Hospital or Attending Physician:	within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of niner: On the basis of e and manner state	examination and	, death occurred at the ti d/or investigation, in my o	me, date a opinion, de	and place, and due to the eath occurred at the time	cause(, date ar	s) and manner a nd place, and du	is stated. te to the cause(s)	
10#	within To the comple	Me	29b. Signature and title of certifier	111		29c. Licens			29d. Da	ate signed (Mon	th, Day, Year)	
	/		Na	ishall		D 2	100	08	3	116	107	
	0		30. Name and address of person who Jim Parshall 910			Type, Print) Drive, Balt	imor	e. Maryland	21	237	 	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	- Company		ST THE Y TOLICE	۱ ک	431		
DHMH	17 Rev 1/2		MAR 1 6	2007	w K	Apack D						_
		501				ORIGINAL						

State Registra

29b. Signature and title of certifie

STANLEY KMAN

31. Date filed (Month, Day, Year)

30. Name and address of person who comp

1308

DHMH 17 Rev 1/2001

eted cause of death (Item 23a) (Type, Print)

29c. License number

BUSINESS CENTER WAY, SUITE 102 - EDGEWOOD,

0

29d. Date signed (Month, Day, Year)

-01903 nathan Pierre	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 083 1									
		1- For State Registrar	Certifica	te of Death			eg. No.			
Physicia edical Exami		1. Decedent's Name (First, Middle,Last) Jonathan Pierr				2. Date of Deat Month March 10,	Day Year 2007	3. Time of Death 1734 hrs		
		4a. Facility Name (if not institution, give street and Route 32 and Samford Road	d number)	4b. City, Town, Ft. Meade	or Location of Death		4c. County of Deat Anne Arundel			
Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birtho	day) If Under 1 Y		_	th(MM/DD/YYYY) 9 Bi	thplace (State or		
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits		
ne Maryland or 28a-f show any fied at once.	ctor	Maryland Anne Arundel 10e. Street and Number	I	Fort Meade)	11	0g. Citizen of What Cou	1 Yes 2 XX		
the Ma a or 28 tified a	Director	7226 G. Hall Street		20755	5		United Sta	tes		
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Ex. miner must be notified at once.	Funeral	1 XXNever Married 2 Married 1 XXV	ed Forces?		an, Mexican, Puerto		White, etc.	ican Indian, Black,		
urs afte tural", miner	d by	3 Widowed 4 Divorced If Yes, Give or Dates: 15. Decedent's Education (Specify only highest	grade completed) 16a. De	ecedent's Usual Occup	pation (Give kind of v		16b. Kind of Business/			
C1 3 mm	Completed	Elementary/Secondary (0-12) Colleg	ge (1-4 or 5+)	iring most of working I , $ exttt{I.C.}$	ife DO NOT use reti	red)	US Air Fo	rce		
5-0036 iled within Hygiene. I other tha the Medic		17. Father's Name (First, Middle, Last) Joseph B. Pierre			18.Mother's Name					
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica.	o Be	19a. Informant's Name/Relationship (Type, Print)) 19b.	Mailing Address (Str	Marie	Woolle	ber, City or Town, State	e, Zip Code)		
MD 2 d 2 shou lth and ? n 27 is r	_	Marie Woolley (mother	10)56 Northwe	est 13Stre			s, F1 33026		
imore, MI Pages I and 2. nent of Health a ant: If item 27		20a. Method of Disposition 1 X Burial 2 Cremation 3 Remov	20b. Place of cremator	Disposition (Name of y or other place) Memorial	March 17,	Date 2007	20c. Location - City or Miami Lake	Town, State		
		4 Donation 5 Other Specify:	Calvar	y onaper i	. lantation	-	Plantation	Florida		
Balti permit. Departm Importa injury o		21. Signature of Funeral Service Licensee	400153				Home,Inc (5633 Old 20735		
Physician		23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.	/ 4 - /					Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final disease a. Multiple						Death		
and the		Sequentially list conditions, b.	as a consequence of):							
	iner		as a consequence of):							
cecuted and transit	Examiner	(I) is ease or injury that initiated	as a consequence of):	·-						
e execut cian and rial - tran	dical	UNPENDED AMEND	ED 20b,c per 1	fh g866 4-	3-07 vt					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwiting 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	ves, outcome of pregnancy ive birth 2 regnant at time of death 5	Fetal death Other (Specify)	3 Ectopic pregna	ancy	23d. Date of deliver Month	y Day Year		
). Bc the der by the a	Phy		inknown ng to death but not resulting	in the underlying caus	se given in Part I	23e. Did to	obacco use contribute to	the cause of death?		
b, P.O. Bo	d by					1 Yes	s 2 No 3 Pro	bably 4 Unknown		
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed			,		24a. Was autop perfo 1 Yes	prior to death?	utopsy findings available completion of cause of		
tal Rection: The certificate ector, page	ம	25. Was case referred to medical		26.Pla	ace of Death (Check					
· Vita	To B	examiner? 1 V Yes 2 No Hospital:		patient 3 DOA			Residence 6 Othe	er: Scene		
ion of tending Pl eath. tor: After the funera			Date of Injury 28b. Ti Month, Day Year) 1728		njury at Work? Yes 2 V No	Operator of	motorcycle which			
Division pital or Attendi ours after death. reral Director: /	Certification:	3 Suicide 6 Could not be 28e.	Place of Injury - At home, far ecify) Major Road / Hig		e building, etc.	or Town, S		ural Route Number, City Meade, MD		
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	Medical C	29a. Certifier 1 Certifying Physician: To the one) 2 Medical Examiner: On the b	asis of examination and/or in	th occurred at the time vestigation, in my opin	, date and place, and nion, death occurred	due to the caus at the time, date	se(s) and manner as sta and place, and due to t	ted. he cause(s)		
To vit	Mec	29b. Signature and title of certifier	ner stated		ense number		29d. Date signed (Me	onth, Day, Year)		
				0.	C.M.E. 		March 11, 2007			
10		30. Name and address of person who completed Mary G. Ripple MD. Deputy Ch	cause of death (Item 23a) ief Medical Examiner	111 Penn Stre	eet, Baltimore, N	MD 21201				
ا S Regis	tate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	ands?						
		1918411 1 1 14 14 14 14 14 14 14 14 14 14 14								

leonard Prahl 07-01543 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 5,10a,b,c,e,f, @?##i@# 8869,07/05/07dhb Registrar Rea No 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Time of Death Month Day February 24, 2007 **Medical Examiner** 1700 hrs Leonard Prahl 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stream near Rt 175 & Blobs Park Rd Anne Arundel Jessup 5. Social Security Number 11 6. Sex Age (In vrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 1 X M 2 F 215-48-9796 Apr 12, 1959 47 CountrMaryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Lakeville Wayne PA 28a-f show 1 Yes 2 X No items 23a or 28a-f sho ist be notified at once. Severn death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HCT Box 19438 7959 Telegraph Road USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14 Race - American Indian, 8lack. must be Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Ë Yes filed within 72 hours after 3 Widowed If Yes. Give Year 4 Divorced Yes 2 X No specify: white "natural" 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 11 K 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 marked other t 17. Father's Name (First, Middle, Last unk 18.Mother's Name (First, Middle, Maiden Surname) Be Dorothy Abbott and Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7959 Telegraph Road Severn, MD Diane Shulski/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 4/6/2007 West Arundel Crematory Odenton, MD state 4 Donation 3 X Other Specify. 22. Name and Address of Facility **Kendon-Panley F.H., P.A. 28** 21. Signature of Americal Service Licensee Onald S. W. 49 Director nn 21224 St 21201 IRaltimore MD 21204
From pications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the Jise e. Approximate Interval **Physician** Between Onset and /Medical Death Undetermined Asphyxia Immedi te Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). **per ME g887 1/15/09** a,27,28a-f, perME,g867, 5 Physician/Medica **23a,27,28d,** c,22,per FH, 23a X UNPENDED signed by the attending physician be detached for use as the burial -5/8/07 TI Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? page certificate ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other₄ FR/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 1 Yes 2 YNo 5 Pending unk Subject was assaulted Director: d in by the Fnd 2/24/2007 Fnd 4:50 pm Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide or Town, State) 175 @Blobs Park Road Jessup, MD (Specify) unk 4 X Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

February 25, 2007

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

To the

29b. Signature and title of certifie

Pamela E. Southall, MD

31. Date filed (Month, Day, Year) MAR 1 0 2007

puthell, nis 30. Name and a brass of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

tanuat;

07-01920 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ira Franklin Parsons State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ 1200 hrs **Medical Examiner** Ira Franklin Parsons March 11, 2007 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Mardela Springs Wicomico 11277 Snethen Church Road 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Director 214-66-8879 Country)Maryland 1X M 2 F 49 Yrs Jan 19. 1958 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 10a State 10b. County Yes 2 X No 28a-f show MD Wicomico Mardela Springs 23a or 28a-f shore, notified at once. Director 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 11277 Snethen Church Road 21837 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. must be or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year Yes 2 X No specify Specify: item 27 is marked other than "natural", - traumatic event, the Medical Examiner Widowed 4 X Divorced white \$ r Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) within 72 more, MD 21215-0036
Pages 1 and 2 should be filed within 73
nent of Health and Mental Hygiene 0 disabled none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Billy Parsons Evelyn Jean Laird 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna Parsons/former spouse Snethen Church Road Mardela Springs. MD 21837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Itimore, t: If it crematory or other place) Burial 2 Cremation 3 Removal from State Important: I 4 X Donation 5 Other Specify 21 Signature of Funeral Stryice Sicensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Raltimore MD 21201

nter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications that caused the death. Do not enter **Physician** Between Onset and failure List only one cause on each line Madient Death Oxycodone intoxication Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical physician a X UNPENDED AMENDED, 7,28a-f, perME, g865, 3/28/07 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Year 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö þ Yes 2 No 3 Probably 4 ✔ Unknown Δ Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autonsy aw has death? performed? 1 🗸 Yes 2 No ✓ Yes 2 No The page certificate 26 Place of Death (Check only one) 25. Was case referred to medica of Vital Be Other₄ Hospital: 1 Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death After Certification: Natural Yes 2 No Pending Fnd 3/11/2007 Fnd 11:09 am 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) $11277 \hspace{0.1cm} Smethen \hspace{0.1cm} Church \hspace{0.1cm} Rd.$ 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined (Specify) Mardale Springs

the Hospital or Attending Physician: Division Director: d in by the f 24 hours after Funeral I To the

> 32. Registrar's Signature 2015

House

Assistant Medical Examiner

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

29a Certifier 1

Medical

one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 12, 2007

			1 - For Amend #4c Per	State of M. PHY G86	aryland / Dep. 3/20/07	artment d	of Health a	nd Me	ntal Hygie	ene () ()	7	083	20
			Decedent's Name (First, Middle, Last)					2.	Date of Death			3. Time of	Death
i, k	Physici		John Wallace Penn:	ington					Month larch	14, 20	Year 07	6:15	A M
	/Medic		4a. Facility Name (If not institution, give			4b. City, To	wn, or Location of	f Death		4c. County	of Death		
			299 Wakely Terrac	æ		Bel	Air			2101	4 Ha	rford	
	Funeral		Social Security Number 6. Security Number	7. Ag	e (In yrs. last birthday)	If Under 1 Y Months D	/ear If Under 2 lays Hours	Min. 8.	Date of Birth (Month, Day, Y	ear)	9. Birthpl Count	ace (State o	r Foreign
١.	Director		220-18-6276	IM ZUF	82 Yrs.			A	or. 30,	1924	Mary	land	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation					10	d. Inside Ci	ty Limits
	Maryfar f show	ō	Maryland Harfor	đ	Bel A	ir						1 🗌 Yes	2 X No
	28a	Director	10e. Street and Number			10f. Zip Co	ode		100	. Citizen of W	hat Count	ry?	
	3a or		299 Wakely Terr	ace			21014			USA			
	ms 2	Funeral		12. Was Decedent	Ever in U.S. 13.	Was Deceden	t of Hispanic Orig	jin? (Specif	y Yes or No-	14. Race	- America		
9	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀	No	_ ` ` `	Cuban, Mexican,	, Puerto Rio	an, etc.)		k, White, e	etc.	
5-0036	ral',	1 by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 25	No Specify:			Specify	Whi	te	
5-0	within 72 hours after death with the Maryland ane. then "netural", or items 23s or 28s-f show is Madical Examirer must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual C	done durina most	of working	16	b. Kind of Bu	siness/Ind	ustry	
2121	hen.	Ig II	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use r	/						
	Hygie Hygie ther t		11. Father's Name (First, Middle, Last)		Truc	k Drive		r's Name /F	irst, Middle, Ma	ranspo			
Maryland	i 2 should be fited within "h and Mental Hygiene. I is marked other then "freumatic event, the Mes	Be		nnington									
Z	nation	10	Charles Bradley Pennington Frances Emily Litt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or									Code)	
<u>≅</u>	is 1 and 2 should be filed within 72 hours after death with the Maryla of Heelth and Mental Hygiene. Item 27 is marked other then "netural", or items 23e or 28e-f show other traumatic event. Ite Medical Exercities result be notified at	ĺ		,		0130 E							
ē,	Hee Hee tem		Ann Sellers / Niec 20a. Method of Disposition	:e			Terrace	Date	AIT, NE	c. Location -	City or To	wn, State	
OF.	Pages nent of int: If it		1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bel Air	matory or othe Memoria		3-17-0	17 Be	ol Air	Mar	bre lu	
Baltimore,			21. Signature of Puneral Service License	90 /			Address of Facility Funeral			-I AII	PACIA	утака	
ñ	permit. Departr Import eny Inj		I stelle (1.	Hercels	M. 5.	CCOMas IW Br	runeral cadway,	Home,	, P. A. Air Mar	ard and	2101	1	
2:	*		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do not en						2101	Approximate Interval Bet	
4	Physician		Immediate Cause (Final disease or condition	CONGE		707	FAIL	IRA				Onset and I	
李	/Medical		resulting in death)		a consequence of):	AT	1716	VIII					
	Examiner		Saquentially list conditions	Sequentially list conditions, CARDIOMYDPATHY									
	D #	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):								
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last								_		
8760,	ale be executed hysician and the burial-transit		Todaming in additing East	Due to (or as	a consequence of):								
8	4 5 5	dlcal		l									
9 X	The law requires that the death certifica He has been signed by the attending phage 2 should be detached for use as it	Physician/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy					and Day	a at alalisa		
Вох	atten for u	lan	in the past 12 months?		2 Fetal death 3	□Ectopic pregr □ Other (speci				Mor	of deliver oth		/ear
P.O.	that the de ed by the detached	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	Sime of death St	_ Other (speci	.,,,						
	that the		Part II. Other significant conditions cor	tributing to death b	ut not resulting in the u	inderlying caus	se given in Part I.		23e. Did toba	cco use contr	bute to the	e cause of d	eath?
rds	uires n sign	D D	HYPERTENSIC)V					1 🗆 Yes	2 🗆 No	3 🗌 Proba	ably 4 D	Inknown
of Vital Records,	w requir s been s should	Completed by	DIABETES A	WELLIT	16			10	24a. Was an	24b. V	Vere autop	sy findings	available
Re	The lav	E O	Director		^9				autopsy	d2 d	rior to con eath?	pletion of c	ause of
tal		0	25. Was case reterred to medical				26. Place	of Death (C	1 ☐ Yes 2 ☐	a No	Yes	2 NO	
<u>></u>	W 17	To B	examiner?	ospital:	ent 2 ER/Outpatie	nt 3 DOA	Othor		5 ☑ Residend	e 6 □Othe	r (Specify)	
0			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o	f 28c.	Injury at Work?	280	f. Describe how	injury occurre	ed		
<u>ō</u>	Attending r death.	atle	2 Accident investigation			М	1 Yes 2 N	10					
Division	I or Attendiater death. Director: A	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, of	ffice	28f	Location (Stree City or Town, S		er or Rural	Route Num	ber,
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	To the Hospitel or Attent within 24 hours after deati To the Funerel Director:	Medical	one) 29b. Signature and title of certifier	and manner st	1100.	29c 1	icense number		794	. Date signed	(Month I	Dev. Year)	
	F 350		MALLO	6000	1.45		1501	7	14	0 /1.	11	¥ ^	7
	D		30. Name and address of person with co	M USAV	Path (Item 22a) (Tun-		1000 A	T	MI	MOCH	14	20	U+
l			VITAY M - A	BHYAN/	WAR 1	NORT	M AVE	. 1	SEL A	TR	MS	210	14
0	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	antis	, , , , ,						
	Registr		MAR 1 5 200	Jacob Com	a to be	4							

Pennington

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day PREDDY **Physician** UCILLE 03 14 2007 2:40a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Summit Park Nursing Home If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
11 01 1 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M **X**(X) Months Days Yrs. 94 Director 212-22-2218 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Catonsville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1502 Frederick Road 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xlo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Black Specify: þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If Item 27 is marked other the any Injury or other traumatic event, the Jones. 12th grade Home Care Nurses Aide Care Provider na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alex Cook Mattie Lewis 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3521 Wild Cherry Road, Baltimore, Md 21244 sposition (Name of Date 20c. Location - City or Town, State Erika Preddy-Daughter-In-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 3/17/07 Pikesville, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Ave, Baltimore, Md 21215 23a. art1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC **Physician** CARDIOVASCULAR DISEAS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. certificate be executed physician and s the burial-tran-Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending properties of the pr 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nnknown Completed was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Mapner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature H4SICIAN OLD COURT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 VERAHALLI HARISH RAMPALLSTOWN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 16 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 15, March Winfield Scott Payne 2007 10:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth

Jan. 20, 1917 9. Birthplace (State or Foreign Country)
Colorado 7. Age (In vrs. last birthday) **Funeral** 1**№** M 2□ F Days Hours 524-05-0459 Yrs. Jan. 90 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f show the notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Parkville. 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 8820 Walther Blvd., Unit #1304 23a 21234 Funeral U.S.A. and 2 should be filed within 72 hours after death a saith and Mental Hygiene. n 72 is marked other than "natural", or items 233 ner traumatic event, the Medical Examiner must ner traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Analyst Defense Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winfield Scott Payne, Sr. Mildred Hulse. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Barbara R. Payne (wife) 8820 Walther Blvd., Unit#1304, Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 3/19/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Lice 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a const quence of): den /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 Certification: To 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? after death.

Director: After t 28d. Describe how injury occurred 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a, Certifier 🐔 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Function

completely for (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

12

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAR 1 6 2007



30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)

1000

Parto. 14 mp 2/239

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State Of M	aiyiaiiu		ificate of	Death		leg. No.) 7	0832	23
			1. Decedent's Name (First, Middle, La	st)					2. Dete of Dea	th	WEST I	3. Time of D	Death
	Physici /Media		JULIANNA	F	PODSI	ADLO			Month March	Day 1 4	Year 2007	8:30	АМ
	Examir		4a Facility Name (If not institution, give					4b. City, Town, or I	ocation of Death	4c. Count	of Death		
			1220 Tugwell Driv	<i>r</i> e				Catonsvi]	lle	Balt	imore	2	
	Funeral		Social Security Number 6. 5	Sex 7. Ag	je (In yrs. las		If Under 1 Year Months Days		8. Date of Birtl (Month, Day	r, <i>Year)</i>	9. Birthp Cour	olace (State or ntry)	Foreign
	Director		212-60-0058 Usual Residence of Decedent	2,231	99	Yrs.			12/17/		Pola	and	
	and and		10a. State 10b. County		10c. City, 7	Town or Loca	ation				1	10d. Inside City	Limits
	Mary 1 sh	ò	Maryland Baltimo	220	Cot	onsvil	1.					1 ☐ Yes	2≱No
	r 28s	9	10e. Street and Number	ле	Lac	OHSVII	10f. Zip Code			l 0g. Citizen of	What Coul	ntry?	
	h wit	a D	1220 Tugwell Driv	<i>r</i> e			21228			Poland			
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Wa		Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-			can Indian,	
336	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at ence.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	No		JYes 2∭ No		,	Specia			
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anc	ntal h	Be						18. Mother's Nan			пе)		
Maryland	hould d Me mark	5	Michael Podsiadlo			19h Mailing	Address (Stree	Katherir		nknown	State 7ir	Code)	
≥	od 2 s					CC PROPERTY.				-			
ē,	s 1 and Head of Head	ı	Sr. Krystyna Mroc 20a. Method of Disposition			e of Disposit	tion (Name of tory or other pla	orive car	Date	20c. Location	City or To	own, State	
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alti	mit. Poertra y Inju		21. Signature of Funeral Service Licer	1500	TOTY	22.1	Name and Addr	ess of Facility	enter i i l'interders		010,	mar y rai	.10
Φ.	89 2 2 8	- 1	Kathlaen) / IVIXI	11			Weber Fune ester Stre			Marul	21° 50c	231
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	Pre	um	nia				2	week	1
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rds	uiras n sign	by Dy	n /		1.				24a. Was a		24b. W	ere autopsy fin	idings
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ta	ysician: The la is certificate ha director, page	0	25. Was case referred to medical					26. Place of Dea	th (Check only or		1		
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Division of Vital Records,	or Att	Certification:	4 Homicide determined	28e. Place of Injude	ury - At home c. <i>(Specify)</i>	, farm, stree	t, factory, office		28f. Location (S City or Tow	treet and Numi n, State)	ber or Rura	al Route Numb	ər,
	ours sours seral (2	29a. Certifier 1 To Certifying Ph	yeician: To the best of	of my knowle	dge, death o	ccurred et the ti	ime, date and place.	end due to the c	ause(s) and m	enner es s	teted.	_
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	1		30. Name end address of person who	completed cause of d	eath (Item 23	Se) (Type, Pr	int) 0 1/	34951	maca	5 - //	0,00	2.15	>
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DHMH 16 Rev 6/95

ORIGINAL

		1	For State Registrar	S	State of Mar	yland /		rtment <i>ificate</i>				R	leg. No	0000	0832	2
Physician			1. Decedent's Name (First, Middle, Last) JOHN JOHN		SEPH PREIS			SINGER				2. Date of Death Month MARCH 1		y 2007	3. Time of Death 10:30 A	A.
0.	/Medica Examine		a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE				4b. City, Town, or Location of Death TIMONIUM						4c		MORE	
	Funeral Director		5. Social Security Number 219-18-8	3174 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last b 81	oirthday)_ Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	Date of Birtl (Month, Day – 25 – 1	, Year)	Coun	lace (State or Foreig try) RYLAND	n n
·ш•)36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of De 10a. State 10 MD	ORE	10c. City, Town or Location ROSEDALE						10d. Inside City Limits 1 Yes X No					
		I Director	10e. Street and Number 8122 WOODHAVEN ROAD			10f. Zip Code 21237						10g. Citizen of What Country? U.S.A.			•	
	rs after death	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	, Was Decedent Ev	cedent Ever in U.S. Forces? § 2 □ No Sive Dates: 1943-45				Hispanic Origin? (Specify Yes or Noban, Mexican, Puerto Rican, etc.) Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
10:26 a.m. 21215-0036	vithin 72 hou ne. han "natura e Medical E	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							OFFICE MACHINES			
	be filed w ntal Hygie ed other ti event, th	Be Co	8 17. Father's Name (<i>Fin</i>	18. Mother's Name (First, Middle, Ma								laiden Surname) KING)				
2007 Maryland	12 should h and Mei 7 is marke traumatic	P	19a. Informant's Name	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
	ages 1 and ent of Healt t: If item 2: y or other		20a. Method of Dispos 1 ☑ Burial 2 ☐ 0			20b. Place ceme	of Dispos etery, cren	sition (Name natory or oti	e of her place	e)	Date			ocation - City or To	•	
MARCH 14, Baltimore	permit. P Departme Importan any injury		21. Signature of Fune		1-3	L PARK	22	. Name and	Addres	s of Facil	ity CVAC	H/RO	SED	ALE FUN	ERAL HON	1E
Zi I			Immediate Cause (Fir	3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or cause (Final Cau												
	Physician /Medical Examiner	Examiner	disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):													
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Division	i di tie	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	To the within 2 To the Comple	Σ	29b. Signature and title of pertifier 29c. License number D 43725								29d. Date signed (<i>Month, Day, Year</i>) 3//4/07					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLET RD. TIMONIUM, MD 21093													(
10	St Regist	ate rar	31. Date filed (Month	n, Day, Year)	32. Registra	r's Signatur	13	Mar.								

			1 - For State Registrar	State of Man		artment of H			ene 007	08325
	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Media	al	Mary C. Phillip						4, 2007	9:35 A M
	Examir	er	4a. Facility Name (If not institution, give s 1207 North Aver				r Location of Deat	n	4c. County of Deat	
_	Funeral		5. Social Security Number 6. Sex	7. Age (II	n yrs. last birthday)	Baltin If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Baltimo	hplace (State or Foreign
L	Director		2.0 21 30.1	^{1 M 2}	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y April 25	, 1907 O	hio
	and w		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town or Lo	ocation				10d. Inside City Limits
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	or 288	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
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	72 hours after death with the Maryland netural', or items 23a or 28s-f ehow dical Examiner must be notilied at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No	or in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	ipecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
036	urs af	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2∏ No	Specify:		Specify:	White
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Maryland 21215-0036	2 should be and Mental ie marked reumatic ev		19a. Informant's Name/Relationship (Ty)						City or Town, State, 2	,
€,	of Health item 27		Nina Mae Phillips	-		termina de la companya del la companya de la compan	enue, Bal		Maryland 2	
Baltimore,	init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan entiment of Health and Mental Hygiene. Cetant: if item 27 ie marked other than "netural", or items 23a or 28a-1 ehow injury or other treumatic event, the Medical Examinar must be neithed at a night of the content of the medical Examinar must be neithed at a night of the medical Examinar must be neithed at a night of the medical Examinar must be neithed at a night of the medical examination.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		20b. Place of Dispo cemetery, crei Meadowri	matory or other place	Dle 2/1		Oc. Location - City or	
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	Physician /Medical Examiner	iner	23a. Part1. Entay the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a co	wosep	sis		c or respiratory arres	it,	Approximate Interval Between Onset and Death
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iois	Attending Physician: ir death. ector: After this certifice by the funeral director, p	atio	Natural 5 Pending investigation	(World, Day 16	sa <i>r)</i> Injury		Yes 2 □No			
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 Physician 2:50 p March 13, PAGE THELMA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Hyattsville 6605 8th Place If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, May 25, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Hours 1 M 2 M F Yrs 1914 Virginia 92 577-42-4584 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 1∩a State 10b. County 28e-f ehow 7 is marked other then "natural", or iteme 23s or 28e-f ebor traumatic event, the Medical Examinar must be recitied at 1 ☐ Yes 2 X No Director Hyattsville Prince Georges MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **IISA** 20783 6605 8th Place death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 is marked other then "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 δ 3 X Widowed 4 □ Divorced **Black** Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) DC Public Schools Music Education Teacher 6yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie Lee Gilbert Pegram ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 Banning P1 Hyattsville, MD. 20783-2848 19a. Informant's Name/Relationship (Type, Print) Arleta Cunningham/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 5 permit. Page Department of Important: If any injury or gnce. Metropolitan Crematory 3-16-2007 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4217 9th St. N.W. Washington, D.C. 20011 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Breast Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 2X No 1 Yes certificate Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 X Natural 5 Pending 1 Tyes 2 No death. neral Director: A filled in by the fo investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ To the Hospital o within 24 hours aft To the Funeral Di 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 11903 DC 3/15/2007 Michny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington, DC 20010 106 Irving St. N.W. Bernard Wilson, MD 31. Date filed (Month, Day, Year) Registrar's Signature_ State MAR 1 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, L Month Yea **Physician** 200 7 /Medical 4c. County of Deal Town, of Location of Death number) not institution, give street and **Examiner** If Under 24 Hrs Birthplace (State or Foreign Country) (In yrs. last birthday) Yrs. Social Security Number 6. Sex **Funeral** Days Months 1 M 2 TE 217-26-026 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County f ehow The Medical Exercites must be notified at 1 ☐ Yes 2 ☐ No Director Marland "netural", or items 23a or 28a-f 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Everyn U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Specify: Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Battimore City Public College (1-4or 5+) Elementary/Secondary (0-12) eacher permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygienn Importent: If Item 27 is marked other the any injury or other treumatic event, ITEM 2006. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lelia Onei 19b. Mailing Address (Street and Number or Rural Route Mumber, City or Town, State, Zip Code) 19a. Informant's ma/Relationship (Type, Print) 8905 Greens Kandallstown Maryland Cooper-dangkter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Marylan Cemete * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furleyal Service Lice Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 LNO 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐NO 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops page 2 1 Yes After this certific funeral director, 26. Place of Death (Check only one) 25. Was case referred to me examiner? Be Hospital: Impatient Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 1 ☐ Yes 25 NO 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Copyring Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) March 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernando A Belgado MD 6701 North Charles Street Suite 4202 Towson MD 21204	Divisi	I or Atten after deat Director: I in by the	ertifica	Z Accident	Place of injury - At homouilding, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location City or T	(Street a	and Number or R te)	ural Route Number,		
D32717 March 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernando A Belgado MD 6701 North Charles Street Suite 4202 Towson MD 21204		e Hospita 24 hours e Funeral letely filled		(Check only 2 Medical Examiner: On	the basis of examinatio	ledge, deat on and/or in	h occurred at the ti	ime, date and p opinion, death	lace, and due to the	e cause(e, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)		
D32717 March 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernando A Belgado MD 6701 North Charles Street Suite 4202 Towson MD 21204		To th within To th comp	Me	29b. Signature and title of certifier										
Fernando A Belgado MD 6701 North Charles Street Suite 4202 Towson MD 21204		,		F. Bilcolon	NO		D32	/17		М	arch 15,	2007		
Company Connective		5						Street	Suite 4	202	Towson M	ID 21204		
	-				on the sistent's Cianatu	Iro								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 SYLVIA PASSEN /Medical Qunty of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and numbe **Examiner** 6050 DACH, Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1 □ M 2 👿 F 69 212-36-5115 MD 06/16/1937 Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2 No ns 23a or 28a-f sh must be notified Director **BROWARD** FORT LAUDERDALE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3055 HARBOR DRIVE #902 U.S.A. 33316 or items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Injury or other traumatic event, the Medical Examiner permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter may Injury or other traumatic event, the Medical Examiner ane. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Yes 2 No 1 ☐ Never Married 2 X Married Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **TEACHER EDUCATION** 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be **HENDLER** FLORENCE TRUSS NATHAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3055 HARBOR DRIVE #902-FT. LAUDERDALE, FL. 33316 SELVIN PASSEN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other HAR SINAI CONG. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/15/2007 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard faller. List only one cause on each line. MD 21208 Immediate Cause (Final disease or condition resulting in death) Physician TUTOIMMINE /Medical Due to (or as a consequence of): Examiner OCOIDA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and for use as the burial-tran After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 pronths? 1 □ Yes 2 Ø No 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□No 25 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 2 ER/Outpatient 3 DOA 1 Tes 1 🔲 Inpatient Medical Certification: To Manufer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: death. within 24 hours after death To the Funeral Director:

death with the Maryland

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

29c License numbe

29d. Date signed (Month, Day, Year)

pall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Mary	Dorothy	Reinhardt	

2007	n	8	0	2	-
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		1- For State Certifica	ate of Death	Reg. No.	2001 00001				
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death				
∕ledical Exam	iner	Mary Dorothy Reinhardt		March 2, 2007	0/15 nrs				
1		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		County of Death				
		Washington County Hospital	Hagerstown		Vashington				
Funeral Director		5. Social Security Numberank 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24Hrs Months Days Hours Mir	—	DD/YYYY) 9. Birthplace (State or unk Foreign Country)				
		Usual Residence of Decedent							
any		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits				
und show	7	MD Washington Hage	rstown		1 Yes 2 X No				
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citiz	zen of What Country?				
th the N 23a or cotified		15635 Deer Lodge Circle	21740		USA				
0036 within 72 hours after death with the Maryland giene. Per than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? unk	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 		 Race - American Indian, Black, White, etc. 				
fler de l'', or		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: white				
ntural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. [Decedent's Usual Occupation (Give kind of	work done unk 16b. K					
136 Thin 72 hours a Than "natural Edical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	ired)					
036	d L	unk unk							
21215-0036 ould be filed within 72 hours al 1 Mental Hygiene, s marked other than "natural it event, the Medical Examin		17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	e (First, Middle, Maiden	Surname) unk				
	o Be	19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street and Number or	Rural Route Number. Ci	ity or Town, State, Zip Code)				
MD 2 ind 2 shoulth and 1 m 27 is r	-		111 Penn Street Bal		21201				
ore, MC es l and 2 s' of Health au If item 27		20a. Method of Disposition 20b. Place of	f Disposition (Name of cemetery,		Location - City or Town, State				
imore, MD 2 Pages I and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		Dullar 2 Clemator 3 Kemova nom state	ory or other place)						
Baltimore, permit Pages I at Department of He Important: If ite	1	4 Donation 5 X Other Specify in state 21. Signarure of Funeral Services identified by Director	32 Name and Address of Facility State Anatomy Boar	d 655 II Da	1.1				
Balt permit Departu Import		and Mille	Baltimore, MD 212	а озэ w. ва 01	illimore Street				
Physician		23a. Partyl. Enter the disease, of complications that caused the death. Do no failure. List only one cause on each line.		or respiratory arrest, sho	Approximate Interval Between Onset and				
Examiner	1	Immediate Cause (Final disease a, Multiple Injuries							
LXdiiiiici		or condition resulting in death) Due to (or as a consequence of):							
	<u> </u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
	اغًا	cause. Enter Underlying Cause							
ed	Examiner	events resulting in death) Last Due to (or as a consequence of):							
760, cate be executed physician and the burial - transi	Medical	UNPENDED AMENDED		***					
760, icate be est physician	₩ Wed	IF FEMALE: 23c. If yes, outcome of pregnancy			d. Date of delivery				
ox 687 eath certific attending p	ician/	23b. Was decedent pregnant in the past 12 months?		ancy	Month Day Year				
Box e death c the atten	ו מי	1 Yes 2 No 9 ✓ Unknown 9 Unknown	Other (Specify)						
O. B. that the died by the detached	Phy	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?				
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COF law 1	Completed by			autopsy performed?	death?				
tal Rection: The certificate ector, page		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 N	lo 1 Yes 2 No				
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of Vital Recing Physician: The After this certificate funeral director, page	<u>1</u>	27. Manner of Death 28a. Date of Injury 28b.	Time of Injury 28c. Injury at Work?	28d. Describe how inju					
Division of Vital Records, tal or Attending Physician: The law requires after death an Director: After this certificate has been seed in by the funeral director, page 2 should it	ertification:	1 Natural 5 Pending Mar 2, 2007	2 hrs 1 Yes 2 ✓ No	Pedestrian struck	t by auto				
risior r Attend ter death irector: n by the	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office building, etc.		and Number or Rural Route Number, City				
Divi pital or A cours after eral Dire	erti	Suicide Could not be determined (Specify) Local Street		or Town, State) Route 40 at Deer Lo	odge Drive, Hagerstown, MD				
Hos 24 h Fun tely	sal C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, an	d due to the cause(s) an	nd manner as stated.				
To the How within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or i and manner stated							
	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year) rch 3, 2007				
		Caladda TTG	O.C.M.E.	IVIAI					
	1	30. Name and address of person who completed cause of death (Item 23a)	11 Penn Street, Baltimore, MD 2	1201					
			TT CITT Officer, Datamore, MD 2						
Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** MARY FRANCES ROBINSON 7:15A M MARCH 12 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE CITY 3616 W. BELVEDERE AVENUE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. VIRGINIA 1 □ M 2 □ F 71 06/07/1935 215-30-4018 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 Nes 2 No MD N/A BALTIMORE CITY Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r USA 21215 3616 W.BELVEDERE AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 'natural', or items dical Examiner mu 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any linury or other traumatic event, the Medical Examiner. once. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL DIRECT CARE AIDE (GNA) 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEONA BROWN ALPHONSO BROWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3609 HAYWARD AVENUE, BALTIMORE, MD 21215 SON SANDY JACKSON JR 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X virial 2 ☐ Cremation 3 ☐ Removal from State KING MEM. PARK 3/20/07 WINDSOR MILL, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Howell Funeral Home 21207 21. Signature Funeral Service License 4600 Liberty Heights Ave, Baltimore, MD disease, or complications that caused the death failure. List only one cause on each line. Approximate Interval Between Onset and Death 1. Enter th diate ause Final **Physician** Due to (or as a consequence of): TEN YEERS resulting in death) /Medical Examiner Sequentially list conditions, if any conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine physician and the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ို 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

KUBERT Kanneth Ruly 2435 West Kelvedere Rie Bellimore MD 3

State

Registrar

31. Date filed (Month, Day,

MAR 1 6 2007

Registrar's Signature

			State of Maryland / Department #5, perFH, geo, 3/23/0/ II Cel	artment of Health and Mo	ental Hygiene	007 08332
			1- State Alleria #5, perin, goos, 5/25/07 11 Cel	rtificate of Death		
	Physicia		Decedent's Name (First, Middle, Last)		Date of Death Month Day	Year 4:10 P M
	/Medic	al	Joan G. Rush		March 12,	2007 4:10 F M
}	Examin	G1	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		
			2214 01d Eastern Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore # Under 1 Year If Under 24 Hrs.	8 Date of Birth	9. Birthplace (State or Foreign Country)
	Funeral Director		$214-40-\frac{0763}{0762}$ 1 M 2 DxF 65 Yrs.	Months Days Hours Min.	(Month, Day, Year) 7-26-1941	Country) MD
	D D		Usual Residence of Decedent			10d. Inside City Limits
	anylar show	_	10a. State 10b. County 10c. City, Town or Lo MD Baltimore Baltimo			1 ☐ Yes 2 ☒ No
	289-f	ectc	MD Baltimore Baltimo	10f. Zip Code	10g Citiz	zen of What Country?
	72 hours after death with the Maryland Institutel; or Items 23a or 28e-f show dicel Exactinations to notified at	Funeral Director	2214 Old Eastern Avenue	21220		SA
	ns 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - American Indian,
ထ	or iter	고	1 Never Married 2 Married 1 ☐ Yes 2 No	If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☐ No <i>Specify:</i>		Black, White, etc. Specify:
Ö	ral', c	d by	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		White
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d 2	filed Hygid Sther		17. Father's Name (First, Middle, Last)		(First, Middle, Maiden	
au	should be ind Mental in marked of	To Be	John Raab	Anna	Zubalik	
Baltimore, Maryland 21215-0036		1-		ng Address (Street and Number or Rura		
Σ	and 2 lealth a m 27 is		THOMAS RUSH	Linden Ave., B		
ore	of He		1 Rurial 2 XIC remation 3 Hemoval from State	matory or other place)		cation - City or Town, State
Ĕ	Pag ment tant:			Crematory 3-17	-07 Bal	Ltimore, MD
3aH	permit. Pages 1 Department of H Important: If Ite any Injury or ot		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Bra	dley-Asht	on Funeral Home
	JUE # 0		23a. Part1. Enter the disease, or complications that caused the death. Do not en			Approximate
		o. 1	shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
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		声	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
3	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.			
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of Vital Records,	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		
to	Phys this aldi	7.	1	int 3 DOA 4 Nursing Hol	ne 5 Residence 28d. Describe how injur	
	fune fune	tion	Natural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No	,	,
Division	Attending or death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s	treet, factory, office	28f. Location (Street an	d Number or Rural Route Number.
Ο̈́	\$ # `	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, State))
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Check only 2 Medical Examiner: On the basis of examination and/or i	th occurred at the time, date and place,	and due to the cause(s)	and manner as stated.
	the H iin 24 the Fi	ledicai	one) and manner stated.			te signed (Month, Day, Year)
	To Too	Σ	29b. Signature and title of certifier.	29c. License number	290. Da	1/4/2007
			7 and Cello	W 3 - 1 2 1	3	111/2001
	20		39 Name and address of rerson who completed cause of death (Item 23a) (Type	INST RAIDMA	a no 2	1264
	T	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	10. 10.10	7 2	
	Regist		MAR 1 6 2007 Januar 15	graves		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 7:27 AM $^{\rm M}$ 2007 David Earl Reed March 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 2205 Old Joppa Rd. Harford Joppa If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days 1**X** M 2□ F 65 Director 06/24/1941 WV 212-36-8534 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show or 28a-f show notified at 1 ☐ Yes 2 No Director MD Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 21085 USA by Funeral 2205 Old Joppa Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes If Yes, Giv Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Continental Can Hygiene. other than ' ent, the Me Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Coordinator Company Pages 1 and 2 should be filed and the filed and Mental Hygid Int. If Item 27 is marked other Ith and Mental Hygie 27 Is marked other if r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ocie Ann Morgan Rodney James Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Reed/Self 2205 Old Joppa Rd. Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If It any injury or c 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-01 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives mul 358 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day **Physician** neumonia /Medical Due to (or as a consequence of): **Examiner** Unnons Sequentially list conditions, if any, leading to in modilate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical ast IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 AResidence 6 ☐ Other (Specify) P Director: After the in by the funeral 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician: within 24 hours af To the Funeral D completely filled in

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year JOEL RIOS MARCH 14 2007 1:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5005 EAST HOFFMAN STREET BALTIMORE | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. | No. last birthday 9. Birthplace (State or Foreign 56 **Funeral** Hours Days **X** M 2□F 467-82-1511 TEXAS Director Usual Residence of Decedent 10c. City, Town or Location 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits N/A BALTIMORE MD 1XIYes 2 TINo Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 7 5005 EAST HOFFMAN STREET 21205 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. 1 M Yes 2 □ No If Yes, Give Year or Dates: VIETNAM 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify. Specify: <u>≽</u> WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE CONSTRUCTION 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked of UNKNOWN RIOS UNKNOWN (UNKNOWN) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21205 5005 EAST HOFFMAN STREET ROSEMARI RIOS/WIFE BALTIMORE, item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3-15-07 METRO CREMATORY CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CO ROMBAY DISEASE **Physician** 10/02 /Medical Due to (or as a consequence of): MELLITUS -TYPE IS 111 **Examiner** DIAMETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 144 PERCISOLETREMIA burial-tran Due to (or as a consequence of) physician Physician/Medical the as 23b. Was decedent pregnant IF FEMALE: ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Colty LIS M No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy perform 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ä Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Shesidence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

o the Funeral Director: A

ompletely filled in by the fu ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

ے Records, Vital Hospital or Attending Physician: Division or

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filed within 72 hours after

Baltimore,

certificate be exect

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within 24

31. Date filed (Month, Day, Year) State Registrar

and manner stated

inu W

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

224 CIRESAGO AVE, 2123 M, MO.

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year HENRY KOBINSON 0448 2007 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BAITIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1/22/39 9. Birthplace (State or Foreign Country) S.Carolina 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Year) Days XXM 2□F Director 68 219-26-8302 Usual Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at XXYes 2 No Baltimore n/a Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21229 USA 708 Dorchester Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ any injury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African-1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: American \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry General Motors Elementary/Secondary (0-12) College (1-4or 5+) Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henderson Robinson ပ Elizabeth Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 Dorchester Rd., Balto. MD 21229 Mary Robinson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation Louden Park Cem. 3/17/07 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie F/H P.A.of Balto. 21. Signature of Funeral Service Licens, 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DEP 110 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ECROTIZING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 Other (specify) 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 1∐ Yes Be (25. Was case referred to medical examiner?
11 Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 🕅 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 9 VA 0102201129 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODRIGHE 22 S. GREENE CARlos STREET BALLIMORE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 6

2007

32 Registrar's Signature

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ark Anthony Robinson	State of Maryland / Department of Health and Mental Hygiene
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		1- For State Registrar	Certificate of L	Death		⊈ U U ; g. No.	00000
Physicia Medical Examir		1. Decedent's Name (First, Middle, Last) Robinson	,		2. Date of Death Month March 12,	Day Year	3. Time of Death 2305 hrs
		4a. Facility Name (if not institution, give street and number) University of Maryland Medical Center		City, Town, or Location of Dea Baltimore	ath	4c. County of Death	7
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 214-78-8772 1 M 2 F Usual Residence of Decedent	4 3	If Under 1 Year If Under 24H Months Days Hours M	Irs. 8. Date of Birth In. Jan 22	- Enrois	thplace (State or gn untry) Maryland
Maryland 28a-f show any d at once.	or		c. City, Town or Location	Baltimore			10d. Inside City Limits 1 Yes 2 No
with the Maryland ms 23a or 28a-f sho	Director	2744 Harten Ave.	1	Of. Zip Code 21216	10	g Citizen of What Coul	ntry?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	by Funeral	11. Married Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced Ir Yes, Give Year	No If Yes,	ecedent of Hispanic Origin? (specify Cuban, Mexican, Puer By 2 No specify:		14. Race - Ameri White, etc.	can Indian, Black,
21 3 =	Completed b	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+)	during most	Usual Occupation (Give kind of of working life. DO NOT use results to Detailer		16b. Kind of Business/I	
	Be Con	17. Father's Name (First, Middle, Last)		18.Mother's Nan	ne (First, Middle, M	aiden Surname)	-
2 3 s	۵[19a. Informant's Name/Relationship (Type, Print) Tear Robinson - mother	19b. Mailing Ad 2744	- Harten A	ve. Bas	per City or Town, State	anyland the
e ta n e l		20a. Wethod of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	20b. Place of Dispositio crematory or other		Date 15 07	Battimore,	Mayland
Baltimo permit Pag Department Important: injury or ot		21. Signature of Funeral Service Propises AUN TANK	35%	e and Address of Facility To	Ker Fun Ave. Ba	timore, M	P.A. 21229 aruland
Physician /Medical Examiner		 23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot V 		node of dying, such as cardiac	or respiratory arres	st, shock, or he á rt	F etween Onset and Death
	١	or condition resulting in death) Due to (or as a conseque Sequentially list conditions,					
1 - 1	틝	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that immated events resulting in death) Last					
e execut ian and ial - tra	Medical E	d. UNPENDED AMENDED					
	cian	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 0 1 Unknown 1	2 Fetal	death 3 Ectopic pregr	nancy	23d. Date of delivery Month D	lay Year
ires that the de signed by the	by Phy	Part II. Other significant conditions contributing to death but	not resulting in the unde	erlying cause given in Part I.		acco use contribute to t	
of Vital Records, Rag Physician: The law requires the this certificate has been significant director, page 2 should be	Completed				24a. Was ar autops perform	24b. Were aut prior to death?	opsy findings available ompletion of cause of
of Vital Rec	္တို- မ်ိ	25. Was case referred to medical examiner?		26.Place of Death (Check	1 Yes 2	No 1 ✓ Ye	s 2 No
of Vil	라	1 V Yes 2 No No Inspiral 1 Inpatient 27 Manner of Death 28a. Date of Injury	2 ER/Outpatient 3 28b. Time of Injur			esidence 6 Other: w injury occurred	
Mar 12, 2007 st. 1						reet and Number or Rur te) Harlem Avenue, Balti	
The state of the s							d.
To with Con	Me	and manner stated 29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	
	-	30. Name and address of person who completed cause of death	(Item 23a)	O.C.M.E.		March 13, 2007	
		Zabiullah Ali, M.D. Assistant Medical Exam	niner 111 Penn S	Street, Baltimore, MD 2	1201		
Sta	(é	31. Date filed (Month, Day, Year) 32 degistrar's Si	ignature	7 _			

07-01983 Horace Staples Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 88337 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Madical Examiner 1237 hrs Horace March 13, 2007 Staples 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 5446 Addison Road Capitol Heights Prince George's **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Days Hours 1 X M 579-40-4901 2 79 Yrs Feb. 11. 1928 **Vir**ginia Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits s 23a or 28a-f show notified at once. 1 X Yes 2 No Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 5446 Addison Road 20743 U.S.A. Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be 14. Race - American Indian, Black, Armed Forces? Never Married 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married 2 X No Yes 3 X Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: it. Pages 1 and 2 should be filed within 72 hours aftitument of Health and Mental Hygiene.
Tant: If item 27 is marked or of holing. Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 8 Lineman Electric 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be (Unknown) (Unknown) 19a. Informant's Name/Relationship (Type, Print) 9b.,Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5446 Addison Road Lewis Lively (Stepson) Capitol Heights. 20743 Itimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 2 Cremation 3 Removal from State rtant: 1 Wood Memorial Park Donation Other Specify 3/17/07 Greer, SC Signature of Funeral Service Licenses 22 Name and Address of Facility Stibling Funeral Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart mer **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Contact Gunshot Wound of Head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical attending physician for use as the burial. UNPENDED AMENDED . Box 68760, the death certificate be e IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the Unknown the Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy has prior to completion of cause of this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical Division of Vital Be 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes No After 28a. Date of Injury FOUND: 27 Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work Certification: Hospital or Attending Subject shot self Natural FOUND Pending Yes 2 🗸 No within 24 hours after death To the Funeral Director: the Mar 13, 2007 1205 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 5446 Addison Road, Capitol Heights , MD determined (Specify) Single Family Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 14, 2007 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Moeth Pay 32. egistrar's Signature State 2007 Registra

ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)
MAR 1 6 2007

and address of person who completed cause

Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Stevenson March Diane A M 1102 /Medical 2007 Betthere City

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Day,

07 22 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 51 Yrs. Director 220-64-5115 Usual Residence of Decedent MD 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heatth and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA X□Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 4012 Walrad Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 🏖 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) School System Crossing Guard llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Rice ပ Walter McCoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 4012 Walrad Street, Baltimore, Md Milton Stevenson Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. Murial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) King Memorial Park 3/19/07 Randallstown, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee al 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Disseminated Intraverilar Coalulation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner osis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to r as a consequence of Examine Metastatic Gastric Carcer bunial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760,^C signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 10 Jnknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 X No has certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 🕅 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Medical Doctor Res - 000 March 13, 2007 103 Hospital, 600 North Wolfe Street, Beltimore, Maryland
32 Registral's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Johns Hopkins 31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

07-01908 **UNK UNK** Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007 08340 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** Month Day March 11, 2007 Damon Smith 0123 hrs Marc 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number 6. Sex 7 Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or oreign Director Months Davs Hours 213-88-5144 X M 2 01 25 69 Country) 38 CТ Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits s 23a or 28a-f show e notified at once. MD NA Baltimore 1 XYes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygone.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho are other event, the Madical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? U.S.A. 5320 Maple Ave 21215 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 X Never Married 2 Married White, etc. Yes 2 X No 3 Widowed If Yes, Give Year Black 4 Divorced Yes 2 X No specify Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 9th grade na Laborer Various Jobs 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Murriel Johnson Deborah Smith 19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Smith-Mother 5320 Maple Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, fimore, 20a. Method of Disposition Date 20c. Location - City or Town, State rtant: V Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: Memorial Park 3/16/07 Randallstown, Signature of Funeral Service Licensee Name and Address of Facility
March F/H West 23a. Part I' Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21215 Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Gunshot wound of torso Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ysician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, attending physi for use as the bu IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Fetal death Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown has been signed by the att 2 should be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' page After this certificate ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes 28a. Date of Injury FOUND: Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Subject shot Natural FOUND: 5 Pending 1 Yes 2 ✔ No after death Funeral Director: tely filled in by the Mar 11, 2007 0101 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 5000 Denmore Ave., Baltimore, Md. (Specify) Alley 4 V Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and itle of certifi 29c License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. March 11, 2007 30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) MAR 1 32. Registrar's Signature State Registrar

07-01972 Jesse Lee Salem Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lesse Lee Salen	n	1- For State Certificate of Death	lental Hygiene	2007 0834
Physicia	an/	Registrar	2. Date of Dea	eg. No. th 3 Time of Death
Medical Exami	ner		Month March 13,	Day Year 0607 hrs
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Funeral			Hada odli Io Bara (B	N/A
Funeral Director		Months Dave I	lours Min.	rth(MM/DD/YYYY) 9 Birthplace (State or Foreign
		Usual Residence of Decedent	JUNE	7.1955 Country) GEORGIA
any		10a State 10b. County 10c. City, Town or Location		10d. Inside City Limits
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re, land Theal Titem		20a. Method of Disposition 20b. Place of Disposition (Name of cemeter crematory or other place) Removal from State	y, Date	20c. Location - City or Town, State
Baltimore, sernit Pages I a Department of He Into Initial Init		4 Dorlation 5 Other Specify: MT, ZION CEME	83-21-07	LANSONWAE MA
Baltimo permit Page Department t Important: injury or ott		21. Signature of Funeral Service Licensee 22. Name and Address of F.		N JR. FUNERAL HOME
		Hacqueline to hour 2140 Nil	-ULTON AVE	BALTIMORE HD 21217
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	fica	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, farm, street, factory, office building 28e. Place of Injury - At home, street, factory, office building 28e. Place of Injury - At home, street, factory, office building 28e. Place of Injury - At home, street, factory, office building 28e. Place of Injury - At home, street, factory, office building 28e. Place of Injury - At home, street, factory, office building 28e. Place of Injury - At home, street, factory, office building 28e.		Street and Number or Rural Route Number, City
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Di To the Hospital within 24 hours a To the Funeral I	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dear and manner stated.		
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		Ch Little (C.		Maron 10, 2007
#	ļ	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimor	e, MD 21201	
St	ate			
Regist		te 31. Date filed (Month, Day, Year) 32. Registrar's Signature		

	an	1. Decedent's Name (First, Middle, Last)				2	2. Date of Dea Month	Dav	y Year	3. Time of Death
/Medic	al	Gene Tunney Shiflett		4b. City, Town, or	r Location of F)eath	03/05	1	. County of Deal	11:40 PM
Examin	er	4a. Facility Name (If not institution, give street and number) Baltimore Washington Medical Cent	ter	Glen Bi		/eau		40.		 Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days		Hrs. 8	3. Date of Birt (Month, Day	h v Year)	0 Rid	hplace (State or Foreign
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and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, T	Town or Loc	cation	.					10d. Inside City Limits
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d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	l li	Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2█ No	an, Mexican, F	? (Spec uerto R	ify Yes or No- ican, etc.)		14. Race - Ame Black, Whit Specify: whi	e, etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft popartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or any Injury or other traumatic event, the Medical Examlonce.	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. [lent's Usual Occup kind of work done o OO NOT use retired	during most o	f working	7		ind of Business	Industry
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should Me mark	۲		19b. Mailin	g Address (Street				er, City o	or Town, State, J	Zip Code)
Ma nd 2 salth ar 27 is		Mrs. Betty Shiflett / wife		lst Ave W				-		
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Baltimol permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service Licensee MO1459		Name and Address			_			
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NAME OF TAXABLE PARTY.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):			•	0.10	COL		
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Or Physi this c	은		VOutpatien 8b. Time of		4 LI Nursi		e 5 Resid		6 ☐Other (Spe	cify)
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Division or Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 Investigation 2	e, farm, stre		-111.	100	3f. Location (5 City or Tov			ural Route Number,
the Hospital hin 24 hours a the Funeral I mpletely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.								
To the to the company of the the the the the the the the the the	M	29b. Signature and title of certifier Ronald Ottanasio MD		29c. Licens	e number 8897				te signed (Moni 3/6/07	th, Day, Year)
10		30. Name and eddress of person who completed cause of death (Item 20)	3a) (Type, I	Print) Pd. Su	ate 108	2. B	allen			1727

State

DR. KELLIETH

31. Date filed (Month, Day, Year)

3R Nakd

pa

DHMH 17 Rev 1/2001

Registrar

9000 7 ean Klin
82. Registrar's Signature

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

Eaddy

07-01803	
Dichard I	Stuckov

Richard L. Sluc	∧ с у	1- For State Registrar	e of Maryland / Depar <i>Certi</i>	tment of Heal <i>ificate of Deal</i>			a. No. 2 A	07 0921				
Physici		1. Decedent's Name (First, Middle,Li		- 1-		2. Date of Death		3. Time of Death				
Medical Exam	ıner	4a. Facility Name (if not institution, g		ckey	Town, or Location of Deat	March 7, 20		1130 hrs				
		University Hospital	ive street and number ,	Baltir		"	4c. County of De	aui				
Funeral			Sex 7. Age (In yrs. las		ler 1 Year If Under 24Hr			Birthplace (State or Foreign Country)				
Director		218-27-887/ 1 PM 2 F / Yrs. Signatury 304990 Miles										
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	<u> </u>	()	10d. Inside City Limits				
A ,	7	nd	6	Baltim	ORE			1 Yes 2 No				
Maryland 28a-f sho	Director	10e. Street and Number		10f. Zip	Code	10	g. Citizen of What Co	ountry?				
th the l 23a or rotifie			leton Stree		21217		USI	7				
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marita Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decede If Yes, speci	ent of Hispanic Origin? (S ify Cuban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,				
ifter de I'', or ier mu		3 Widowed 4 Divorce	1 Yes 2 No	1 Yes 2	No specify:		Specify:	Black				
hours a natura Cxami	ed by	15. Decedent's Education (Specify	only highest grade completed) 1	16a. Decedent's Usual	Occupation (Give kind of rking life, DO NOT use re		16b. Kind of Busines					
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medk at Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		udent	illed)	Fdue	ation				
5-00 ed with tygiene other t	Com	17. Father's Name (First, Middle, Las	it)	******		e (First, Middle, M						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be		priggs	2-16 CO 12-20 C	Luce	/	ckey					
C 유모 · 호	ဥ	19a. Informant Name/Relationshi			S (Street and Number of Reisterto		1 1	1 1				
두 글 등 등 등		20a. Method of Disposition	20b. Pia	ace of Disposition (Na	me of cemetery,	Date	20c. Location - City	for Md. or Town, State				
Baltimore, permit. Pages I a Department of He Important; If Ite		1 Burial 2 Cremation 3 4 Donation 5 Other Specia] M. J.	ematory or other place - Carmel		117/07	Balto. 1	nd,				
Baltimot permit. Page Department Important;	Н	21. Signature Fun Al Service Li			Address of Facility /6	39 W. BF	readeray.	Balte. Ned.				
	3	35a. Part I. Enter the disease, or com	policetions that accord the death D	Mille		rolitan	Chapel	P.C				
Physician /Medical	1	failure. List only one cause on	each line.	o not enter the mode	or dying, such as cardiac	or respiratory arres	st, snock, owneart	Approximate Interval Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death)	Gunshot wound of head Due to (or as a consequence of):					Decar				
	<u>-</u>	Sequentially list conditions, if any, leading to immediate										
	Examiner	cause Enter Underlying Cause	Due to (or as a consequence of):					_U				
W a sign		events resulting in death) Last	Due to (or as a consequence of):									
760, frate be executed sphysician and the burial - transit	Medical	UNPENDED	AMENDED									
K 68760, n certificate be exe ending physician a		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnat	ncy			23d. Date of delive	ery				
Box 687 death certification in a attending performs as the	cian	past 12 months?	1 Live birth 4 Pregnant at time of death	2 Fetal death 5 Other (Spe	3 Ectopic pregn	ancy	Month	Day Year				
Box 687 The death certific the attending produce as the	Physician/	1 Yes 2 No 9 Unknow	9 Unknown									
ires that the c signed by th	by P	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying	g cause given in Part I.			to the cause of death?				
ords, w requires as been sig	ted					24a. Was ar		autopsy findings available				
e law r e has b ge 2 sh	Completed					autopsy perform	y prior to ned? death?	completion of cause of				
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical			26.Place of Death (Check	1 ✓ Yes 2	No 1 🗸	Yes 2 No				
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 ✓ Inpatient 2 E		Other:		esidence 6 Oth	ner:				
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	ä	27. Manner of Death 1 Natural 5 Dending	(Month Day Year)	8b. Time of Injury :	28c. Injury at Work?	28d. Describe ho Subject shot	w injury occurred					
Sior Attend r death ector: by the	catic	2 Accident 5 Pending Investiga	tion		1 Yes 2 V No							
Divi	Certification:	3 Suicide 6 Could no determine		e, iami, street, iactory	, office building, etc.	or Town, Sta 1115 North Ella	reet and Number or i ite) imont Street, Baltii	Rural Route Number, City				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier (Check only 1 Certifying Physic	cian: To the best of my knowledge,			due to the cause	(s) and manner as st	ated.				
To the Hos within 24 h To the Fur completely	Medical		er:On the basis of examination and/ and manner stated.					1.7				
	2	29b. Signature and title of certifier	,	290	O.C.M.E.		29d. Date signed (M March 10, 2007					
	+	30. Name and address of person who	completed cause of death (Item 23	Ba)	O. Convince		wardi 10, 200/					
\		W	eputy Chief Medical Examir	,	Street, Baltimore, M	ID 21201						
St Regist		31. Date filed (Month, Day, Year) MAR 1 6	32. Regetrar's Signature	13 Sparle	9							
Regist	i ell	MAR J. U	LOU JULIAN F	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08345 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 2007 MARTHA STIEFEL 3:34 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 37 STONEHENGE CIRCLE APT. BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 💥 F Days Months Hours 218-16-1747 Director 81 11/4/1925 VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD) BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 STONEHENGE CIRCLE 21208 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □ Yes XX No Specify ģ Specify. 3 XVidowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REALTOR REAL ESTATE is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID SHAPIRO TILLIE KLING 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 is other tra DAVID FOX/SON 7 HENDERSON HILL; MONKTON, MD 21111 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o once. Nation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI 3/14/2007 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD; BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Nronic 15 years Physician /Medical Due to (or as a consequence of) Examiner Equentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has b irector, page 2 s autopsy performed? death? 2 □ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Yes 2 No after death | Director; / d in by the f 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hosping within 24 hours after To the Funeral Dir 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2360 Wes

29c. License number

29d. Date signed (Month, Day, Year)

Jappa Rd Lutherville MD 21093

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Year **Physician** Month March 11, Fred 3:19 рм Shupe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 218 Willow Avenue Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Pay, Dec 31, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☑ M 2 ☐ F Virginia 225-38-3727 74 Vrs Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or iteme 23s or 28s-f show the Medical Exeminer must be notified at Be Completed by Funeral Director 1 ☐ Yes 2 ☑ No MD Baltimore Towson 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 218 Willow Avenue 21286 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Car Salesman Automobile . Pages 1 end 2 should be filed vitment of Heelth and Mental Hygie tent: If Item 27 is marked other Jury or other traumatic avant, IL. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fred D. Sr. Shupe Effie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles D. Thomas-nephew 6206 Ebenezer Rd., Middle River, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment o important: If any injury or once. Hilltop Serv Corp 4 ☐ Donation 5 ☐ Other (Specify) 03/16/07 Towson, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Pnysician HASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physicien and the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. rithis certificate has been signed ral director, page 2 should be det Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu death. 2 ☐ Accident 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21809 M.D. MANCH, 13 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9.5. PRABHI 2336 YORK MO TIMONIUM MD 21093 31. Date filed (Month, Day, Year) 3 Registrar's Signature State MAR 16 Registrar 2007

68760,	
Box	
P.O.	
Records,	
r Vital	
Division o	

		Please Type or Print in BI State of Maryland						le.		
76		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of	Death		eg. No. 200	7 08347		
Physici /Medio	cal_	ENRICO TUMMINELLO		4.00		2. Date of Dear Month	13 2	Year 9:20 PM		
Examir	ier	4a. Facility Name (If not institution, give street and number) OAK CREST			r Location of Death Ville		4c. County of Balt	i Death imore		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 218-03-9689 1 M 2 F 89 Usual Residence of Decedent	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Aug 17,	Y-1/917	9. Birthplace (State or Foreign Country) _Ouisiana		
Maryland -f show fled at	tor	10a. State 10b. County 10c. City,	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 💆 No		
th with the 23a or 28a ast be noti	Funeral Director	10e. Street and Number 8800 Walther, Blvd		10f. Zip Code 21 234		1	0g. Citizen of Wh	•		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub- I ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
vithin 72 ho ne. han "natu	Completed	(Specity only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. E		pation during most of work d)	ing	16b. Kind of Busi			
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and 2 shu ealth and n 27 Is m		Samuel Tumminello-son	20	Glamis G	and Number or Run arth, Bal					
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permit Depar Impor any in		21. Signature of Funeral Service Licensee William G. Da		050 York	Rd., Tow	som, MD	21 204	Home, Inc.		
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be executed ician and burial-transit	sal Examiner	5								
Hospital or Attending Physician: The law requires that the death certificate 4 hours after death. Funeral Director: After this certificate has been signed by the attending physically filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deati	eath 3l	Ectopic pregnancy Other (specify)			23d. Date o Month			
equires tha	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the conditions contributing to death but not resulting in the underlying cause given in Part I.								
The law re ate has be page 2 sho	Completed					24a. Was an autopsy perform	ed? / dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No		
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the Hospita hin 24 hours the Funeral npletely filled	Medical Co	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowled 2 ☐ Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the timestigation, in my op	le, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	ise(s) and manne te and place, and	er as stated. due to the cause(s)		
To th within To th	Me	29b. Signature and title of certifier MD		29c. License	number 1785	290	Date signed (N	fonth, Day, Year)		
6		30. Name and address of person who completed cause of death (Item 23:			1 700	/	0/11/			
Stat	е	31. Date filed (Month, Day, Year) 32 Registrar's Signature	rime	r Boyle	lard to	irkville,	MOZ	1734		
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DHMH 17 Rev 1/2001

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п	Dhuaia		1. Decedent's Name (First, Midd	fle, Last)	1				2. Date of Dea			3. Time of Death	
	Physic /Medi		Bernadine	I,			West	1	March	14,	2007	1230 PM	
	Exami		4a. Fecility Name (If not institution	-	number)		4b. City, Town, or	Location of	f Death		4c. Co	unty of Death	
			8222 Dundalk A		Dunda					ltimor	e		
	Funeral Director		5. Social Security Number 212–34–7007	6. Sex 1 ☐ M 2 💢 F		rs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day October 2	28 , 1937	9. Birth Cou Mary	place (State or Foreign ntry) Land
	and		Usual Residence of Decedent 10a. State 10b. Count	y	10c. (City, Town or Lo	cation					T	10d. Inside City Limits
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	3a or		8222 Dundalk A	zenue			21222			'	US		rid y :
	death	Funeral	11. Marital Status	12. Was De	cedent Ever in	U.S. 13. V			in? (Spec	ify Yes or No-		Race - Ameri	can Indian
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or itame 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Vac C	2X No		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 No	Specify:	Puèrto R	ican, etc.)		Black, White, ec <i>ify:</i> Whi	etc.
ည	72 ho	Completed		nt's Education	4)	16a. Deced	lent's Usual Occupa	ition			16b. Kind o	of Business/In	dustry
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N	filed wi Hygien other th	S	8 years			Bu	ilding Gu	ard			State	of Ma	ryland
2	be fill d oth	Be	17. Father's Name (First, Middle	Last)				18. Mother	's Name (First, Middle, I	Maiden Sun	name)	
<u>×</u>	should I nd Meni r marke umatic	ို	Author Grace					Dora	Snyc	der			
Maryland	2 sh and is m		19a. Informant's Name/Relation				g Address (Street a						Code)
	1 and 2 Health tem 27 i		Harry J. West	Jr. Husi	band		Dundalk A	venue	, Dur	ndalk,M	aryla	nd 21	222
Baltimore,	permit. Pages 1 Department of P Important: If ite ony injury or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5)	3 □Removal from	n State		sition (Name of natory or other place Paith Cemete		arch 1 2007	17,		on-City or To Lle, Ma	own, State aryland
Balt	Depart Depart Import eny inj		21. Signature of Funeral Service	Licensee		22 Cc 7	Name and Address Onnelly Fi 110 Solle	s of Facility. UNETA.	1 Hom	ne Of Di	undall	k,P.A.	21 222
			23a. Part Lenter the disease, o shock, or heart failure. Lis	r complications that	caused the de	ath. Do not ente	or the mode of dying	, such as ca	ardiac or i	respiratory arre	est,	. وللآلام	Approximate
	Physician		Immediate Cause (Final disease or condition	1		7							Interval Between Onset and Death
	/Medical		resulting in death)	a	(or as Oconse	Lance of):	<i>Y</i>						6 months
	Examiner				(0. 00 00.100	74401100 01).							
7		Je.	Sequentially list conditions,	b. Due to	(ur as a eones	iquance of):							
	s be executed sicien and burial-transit	Examin	that initiated events	\$.									
o o	en ar en ar rial-ti	EX	resulting in death) Last	Due to	(or as a conse	quence of):							
8760,	icate be executed physicien and ithe burial-transit	dicai		d									
		Ved	IE ECMAN E	1									-
.O. Box	at the death certifi by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐Live	utcome of pregr birth 2 □ Fel Inant at time of nown	tal death 3 🗌	Ectopic pregnancy Other (specify)					Date of delive Month	ory Day Year
J	that hed by deta	Y P	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the un	derlying cause giver	n in Part I.		23e. Did tob	acco use c	ontribute to th	ne cause of death?
Hecords,	iaw requires that the as been signed by th 2 should be detache	Completed by							_		s 2□No		N/
ec	e law has b	jd							_	24a. Was an autopsy	, ,	prior to cor	osy findings available impletion of cause of
	page 1	S								perform 1 Yes 2	ed? ™ No	death?	2[Z]No
VITa	Physician: this certifical ral director, p	Be	25. Was case referred to medica examiner?					26. Place o	f Death (Check only one			
ō	Physic this c	P	1 ☐ Yes 2 💢 No			ER/Outpatient		4 🗆 Nurs	ing Home	5 Resider	nce 6 🗆 C	Other (Specify	•)
	After	ation;	27. Manner of Death 1 Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	of Injury oth, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 \(\text{Y} \)	at es 2 □ No	1	d. Describe how	w injury occ	urred	
-	- 9 - 7	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 288. Place	e of Injury · At t ling, etc. (Spec	nome, farm, stre ify)	et, factory, office		28f	Location (Str. City or Town,	eet and Nui State)	mber or Rura	Route Number.
:	To the Hospital or within 24 hours aff To the Funerel Di completely filled in	edical	29a. Certifier 1 Cartifyir (Check only one) 1 Madical	ig Physician: To the Examiner: On the b and man	e best of my kn basis of examin nner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my opin	, date and p nion, death	place, and occurred	due to the car at the time, da	use(s) and te and plac	manner as sta e, and due to	ated. the cause(s)
	vithin To the compl	×	29b. Signature and title of certifie	A			29c. License i	number	-	29 M	d. Date sign	ned (Month, L	Day, Year)
	10		30. Name and address of person	who completed cause	se of death (Ite	m 23a) (Type, P	rint)	lleat	t. T.	od Ro	O AL	> 11	200 7 21015
	Sta	te	31. Date filed (Month, Day, Year)	32	legistrar's Sign	ature	-00107 10	-7	- /	VI ISE	1111	- / 1/ L	, 21015
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0021 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** FLORENCE WARTOW MARCH 2007 3:46 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SINAI HOSPITAL BALTIMORE If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F Director 217-07-9725 89 11/09/1917 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD BALTIMORE 1 ☐ Yes 2 No OWINGS MILLS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 WYNDHAM CIRCLE UNIT I 21117 Funeral U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. In Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine once. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS SANDLER CELIA HAMBURG ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R 305 WYNDHAM CIRCLE UNIT I - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of Cemetery, crematory or other place) BETH EL MEMORIAL 03/14/2007 RANDALLSTOWN, MD FRANCINE WARTOW / DAUGHTER 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiacon respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transit The law requires that the death certificate be executed Due to (or as a consequence physician by Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No Month Dav Year 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has by autopsy 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 2 1 Yes 1 Inpatient 2 ER/Outpatient 3☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, Division or Vital Records, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital

Medical

29a. Certifier

State Registrar 29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

16090

death (Item 23a) (Type, Print)

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MAR 1 6 2007

			1 - For State Registrar	State of I	Maryland / De	partmen ertificat				giene 2	007	00350
	Dhysisi		1. Decedent's Name (First, Middle, Li						2. Date of De Month March 7		Year	3. Time of Death
	Physici /Medio		Geraldine Eva	Young								8:30 AM
1	Examir	er	4a. Facility Name (If not institution, gi					cation of Dea	ath		ounty of Death	
			Ft. Washington H				Washin	under 24 Hr	'S C Date of Bir		nce Ge	
п	Funeral			Sex 7. 1 ☐ M 2 🛣 F	Age (In yrs. last birthd 81 Yrs	Months		Hours Min	n. (Month, Da	v. Year)	Cou	place (State or Foreign intry) sinia
	Director		229-40-6519 Usuaf Residence of Decedent		01				Oct. 6,	1723	VILE	SIIII a
	land ow		10a. State 10b. County		10c. City, Town o	Location						10d. Inside City Limits
	Man Feb	ţō	MD Prince	George's	Oxon Hi	.11						1 🙀 Yes 2 🗌 No
	r 288	irec	10e. Street and Number			10f. Zip	Code			10g. Citizer	of What Cou	intry?
	h witi	a D	7314 Leyte Drive	2			2074	1 5		USA		
	is 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 23 er marked other than "natural, or items 23e or 28s-f show other treumatic event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	3. Was Dece If Yes, spe	dent of Hispa cify Cuban, I	anic Origin? (Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14.	Race - Amer Black, White	
36	or it	by Fu	14 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give		1 🗆 Yes	2 X No S	Specity:		S	oecify: Bla	ck
215-0036	fural!	d b	15. Decedent's E	Year or Date	5-7	cedent's Usu	al Occupatio	0			of Business/li	
15	n 72	Completed	(Specify only highest gi	rade completed)	(G	ive kind of wo e. DO NOT u	al Occupatio ork done duri ose retired)	ng most of w	orking	100, Kiliu	OI DUSINGSS/II	laustry
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9	filed Hygi other		17. Father's Name (First, Middle, Las	t)			18	. Mother's N	ame (First, Middle,	Maiden Su	тате)	
Maryland	2 should be fited within and Mental Hygiene. Ie marked other than eumatic event, tre Mi	To Be	Peter Sherman Yo	oung				Lottie	Corr Bu	sh		
ary	should b and Ment marked umatic	-	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address	s (Street and	Number or I	Rural Route Numb	er, City or T	own, State, Zi	p Code)
	end 2 salth a n 27 is		Floraine Eva Cur	ningham/	Dau 731	4 Leyt	e Driv	e, Oxo	on Hill,	MD 2	0745	
Baltimore,	permit. Pages 1 end 2 Department of Health a Important: if item 27 is any injury or other tre		20a. Method of Disposition	Domewal from Cta	20b. Place of Di	sposition (National National N	me of other place)		Date	20c. Loca	tion - City or T	own, State
Ē	Pages nent of ant: if it ary or o		1 ☐ Burial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec		Mt. Oli	ve Bap	t. Ch	urch 3-	-14-07	Hu	ıstle,	VA
atti	permit. Departn Imports any inju		21. Sign Ture of F neral Service Lice	ensee		22. Name at	nd Address o	f Facility	1 Home			
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8760, <	Physician // // // // // // // // // // // // //	lical Examiner	shock, or heart faifure. List only Immediate Cause (Final disease or condition resufting in death) Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	as a consequence of): as a consequence of):	ha	- \(\)	Di	slin	<i>c</i>		Interval Between
P.O. Box 6	The law requires that the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	if FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		2 Fetal death tat time of death	3 □Ectopic p 5 □ Other (s _i				230	I. Date of delive	rery Day Year
	w requires that been signed b should be dete	5	Part II. Other significant conditions	contributing to deat	n but not resulting in th	e underlying o	cause given i	n Part I.	23e. Did t			the cause of death?
I Records,		Completed				<u>-</u>			24a. Was autor perfo	an 2 Osy ormad? 2 No	24b. Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 No
/ita	iclen: Th certificete rector, pag	Be	25. Was case referred to medical examiner?					S. Place of D	eath (Check only o	one)		
of Vital	Physic this c	၉	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp					Home 5 ☐ Resi			ify)
	Ing P	ö	27. Manner of Death 1 Natural 5 ☐ Pending		njury 28b. Tim Day Year) Inju		28c. fnjury at Work?		28d. Describe	now injury o	ccurred	
Division	Attending Physicien: r death. ector: After this certifice by the funeral director, i	Certification:	2 Accident investigate 3 Suicide 6 Could not	be as Start	laines Athama farm	M		2 □ No	28f Location /	Stroot and A	lumbor or Du	al Route Number,
Σ	or Al	i i	4 Homicide determined	286. Place of	Injury - At home, farm etc. (Specify)	street, ractor	у, опісе		City or To	wn, State)	umber or Hur	ar noute Number,
u	To the Mospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai Ce	29a. Certifier 1 Certifying P	hysician: To the beariner: On the basi	est of my knowledge, d s of examination and/o stated.	eath occurred r investigation	at the time, n, in my opini	date and pla on, death oc	ce, and due to the curred at the time,	cause(s) an date and pl	d manner as ace, and due	stated, to the cause(s)
	o the	Me	29b. Signature and title of pertifier			29	c. License ne	umber	-	29d. Date s	igned (Month	Day, Year)
	- s + 0		1/1	7/1		The state of the s	1)-	245	35	0:	3 12	07
	7.1		30. Name and address of person who	completed cause of	of death (ftem 23a) (Tv	pe, Print)						
	h		Laxima Berwa, MI	•	old Branch		.01 C	linton	, MD 207	35		
	Sta	ite	31. Date filed (Month, Day, Year)		strar's Signature	A						
	Regist		MAR 1 6 2	007	un B. L	noste						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 7, **Physician** William Ignatius Armsworthy, Jr. Рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's 22621 Three Notch Road California If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Mary land 220-22-9331 February 17,1921 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2XXNo Director Maryland St. Marv's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22621 Three Notch Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Gas Company 10 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ignatius Armsworthy, Sr. Susie C. Hayden ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Anna Mae Armsworthy / Wife 22621 Three Notch Road, California, Maryland 20619 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Holy Face Cemetery 12, 2007 Great Mills, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licens P.O. Box 270, Leonardtown, Maryland 20650 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Althimers **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter prospering Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by right sided 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) rector, page 2 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ၉ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1/X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No thours after death. uneral Director: A ely filled in by the fu 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar (Check only

29b. Signature and title of certifier

homas M. Wilkinson

32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

attending

23140 Monkley St. Svite 2, MO JAGARE S

00055682

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Leonardtown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend # 12 & #16a & #16b perc ######### 2007 Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** WILLIAM ALLEN 9:10 PM MARCH 2007 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NIA UNIVERSITY OF MARYLAND MEDICAL CENTER 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 12 M 2□F Months Days Hours 212-50-9365 59 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at FREDERICK 1 Yes 2 No MD. FREDURICK Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6TH ST ApT 2 100 EAST 21701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 22 No 1f Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: BL Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Handyman Laborer Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HANDYMAN/LABORGE Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the I 12-174 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KAYMOND A. VIRGINIA GREEN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (moller WEST SOUTH ST FREDGRUN MO 21701 VIRGINIA SMITH 412 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State FREDERICA MD. FARVIGO com. 3-10-67 4 □ Donation 5 □ Other (Specify) ROWINS 22. Name and Address of Facility CARY 21. Signature of Funeral Service License 6. raus X. ST TREDGRIUR 21701 110 WEST SOUTH Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and -tran Due to (or as a consequence of): attending physician a for use as the burial-Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the ...
within 24 hours ...
To the Funeral Divelight filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M.D MARCH 2, 2007

Registrar DHMH 17 Rev 1/2001

State

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DORSOM

MAR 0 5 2007

ANDROW 31. Date filed (Month, Day, Year) UMMC

32. Registrar's Signature

17410

GREENE ST

BALTIMORE, MD

2/201

		For State	State of Marylar		artment of F			giene 07	08353
- Ab		Registrar 1. Decedent's Name (First, Middle, Las.)		rimouto or i	Journ .	2. Date of De	ath	3. Time of Death
Physic		James W. Alvanos					Month Februar	Day Year rv. 28 2007	7:00 P M
/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	I CDI GO	4c. County of Dea	
	*	Charlotte Hall Ve	eterans Home		Charlott	te Hall		St. Mary	's
Funeral Director		230-05-3907	7. Age (In yrs	. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Ba larch 2	y, 1919 Vir	thplace (State or Foreign puntry) ginia
and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
Mary Feb	ţ	Maryland St. Ma	ry's	Charlo	tte Hall				1 □Yes 27 No
with the 3a or 28a	al Director	10e. Street and Number 29449 Charlotte	Hall Rd.		10f. Zip Code 20622	2		10g. Citizen of What Co	ountry?
ges 1 end 2 should be filed within 72 hours after death with the Maryland tof Health and Menial Hygiene. If item 27 ie marked other than "naturel", or itams 23a or 28s-f ehow or other traumatic avent, the Medical Exabiling must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 TYes 2 No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	tispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black, Whit	
2 hor	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation during most of work	(ng	16b. Kind of Business	/Industry
ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most or work d)	ing		
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2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, the Missing and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Mental and Men	To Be	17. Father's Name (First, Middle, Last) William Alvanos				Virgini	a White		
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1 end Health Iem 27		20a. Method of Disposition	20b.	Place of Disp	osition (Name of		Date	Twp., PA 16	
permit. Peges 1 end 2 Department of Health a Important: if item 27 is any injury or other trai		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Br	instie	natory or other place 1d-Echols	Crem. Ma	rch ₂₀₀₇	7 Charlott	e Hall.MD
Depa impo		21. Signature of Funeral Service Licens	MOOO	641 3	2. Name and Addre 0195 Thre	ss of Facility Bri	nsfield. Cha	l-Echols F. arlotte Hal	H., P.A.,
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a. Advar	red	Don	nentio	a.		Onset and Death
/Medical		resulting in death)	Due to (or as a conse-	quence of):			,	. 4	
Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Wev ni C		SEV	1 cepl	10/0	pathy	
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icate be exphysicien s the buria	Physician/Medical	(a hyper						
eath certific ettending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		¬-			23d. Date of de	livery
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Physicien: The law riths certificete has trail director, page 2 s	0	25. Was case referred to medical	cer a	sea	<i>ay</i>	26. Place of Death	1 ☐ Yes	2 No 1 Yes	210 No
nysicl nis cer direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2] ER/Outpatie	nt 3 DOA Oth			dence 6 □Other (Spe	city)
ing Pl		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe t	how injury occurred	
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after after din by	Certification:	4 Homicide determined	building, etc. (Speci	ify)	reet, factory, office		City or Tox	wn, State)	urar noute Number,
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	esician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, deal ation and/or in	th occurred at the time estigation, in my o	me, date and place, pinion, death occurr	and due to the e	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
To the vithin To the Comple	Me	29b. Signature and title of certifier	lf.		29c. Licens	e number		29d. Pate signed (Mont	h, Day, Year)
£ -0		Janel 1	Dun	1_	· D4	5092		5/6/20	00/
クなく		30. Name and address of person who	ompleted cause of death (Ite	m 23a) (Type	Print)#	- Di	non E	- disc	1, 1,5
Sta	at o	31. Date filed (Month, Day, Year)	32. Registrar's Sign	SUL	W XU	1) 111	rice 1	YEUVIU	1 / ML
Regist		MAR 0 7	2007	di.	Soul a				. 206
OHMH 17 Rev 1/2	001			OPIC	INIAI				
				ORIG	INAL				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per verb 9865 3-16-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEB. Year **Physician** Lillian T. Brundick 27 1355-M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death . 4b. City, Town, or Location of Death Examiner ENINSULA REGIONAL MEDICAL CENTER SALISBURY Wicomico If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2X □ F Director 218-28-2762 73 8-25-1933 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 24 ☐ No Director Delaware Sussex Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15825 Trap Drive 19956 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jin Der ပ Marian Warley other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any injury or other trau 15825 Trap Drive Laurel, De. 19956 Calvin Brundick, Sr./Husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 2-28-2007 Delmar, Delaware . Signature of Funeral Service Licenses 22. Name and Address of Facility 700 West Street Hannigan-Short-Disharoon F.H

23a. Part1. Enter the disease, or complications that cave ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Hannigan-Short-Disharoon F.H. Laurel, De. 19956 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CELL LUNG CARCINOMA SMALL months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ RENAL INSUFFICIENCY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 No this certificate 1∐ Yes Hospital or Attending Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral s after death. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO Doo6 2916 JEb. 28, 2007

State Registrar SVETLANA

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

1415 South Division St. SAlisbury Md 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

GUTIERREZ

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 7, 2007 Physician 12:30 Am Shirley Broidy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Waldorf 2240 Community Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day Year NOV. 5, 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Washington, DC 579-58-6728 59 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tem 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 K No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20601 2240 Community Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** 1 ☐ Yes 2 🔀 No Specify. þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Human Resource Specialist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Medley 1 Clarence Roach Corrine ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2240 Community Drive Waldorf, Maryland 20601 Antonio Haskins / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 03/13/2007 Clinton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fund Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 212 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760たな

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director:

10 Registrar

Medical

31. Date filed (Month, Day,

6

29b. Signature and title of certifier

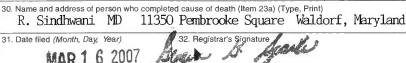
4 Homicide

(Check only

29a, Certifier

2007

and manner stated



Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 61414

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Louis Urban Billing, Sr. March 2, 10:10P M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans Home Charlotte Hall ST. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 → M 2 □ F 218-14-8047 Yrs. 84 October 5,1922 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4114 Morovia Rd. 21206 USA Be Completed by Funeral and 2 should be filed within 72 hours after death viealth and Mental Hygiene. m 27 is marked other than "natural", or items 23s her traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S.
Armed Forces?

1 Ayes 2 No 194
If Yes, Give
Year or Dates: 194 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1943 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 1946 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Shipping Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Billing Emma Weston ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tratonce. Louis Billing, Jr./Son 4114 Morovia Rd., Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 6. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem. 2007 Charlotte Hall, MD 22. Name and Address of Facility Erinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -una disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner UPOX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disease The law requires that the death certificate be executed the burial-tran Due to (or as a consequence scular Diseas Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death signed by the at d be detached fo 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who cause of death (Item 23a) (Type, Print) Hos 0a

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

MAR 0 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year WYNO Harper February 2300 PM 2007 28 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Chester River Hospital Center
6. Sex 7. Age (In Chestertown Kent 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F Months Days Hours 169-40-9730 Yrs. Director 57 06/08/1949 PA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
snt: If Item 27 Ie marked other than "netural", or Itams 23a or 28a-1 ehow ury or other traumatic event, the Madical Examinar must be notified at Director MD KENT CHESTERTOWN 1 Yes 2/No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22467 GOOSE HOLLOW DRIVE USA 21620 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER DISTRIBUTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOCK WOOD BIXBY VERNE CUTHBERT ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA A. BIXBY/WIFE 22467 GOOSE HOLLOW DRIVE, CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. CHESAPEAKE CREMATORY | 03/02/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 130 SPEER ROAD, CHESTERTOWN, MD 21620 Fello 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WIDELY METASTATIC ADENUCARCINOMA, ESOPHAGOS disease or condition resulting in death) 6 month /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attanding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant jo in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by PULMONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 203-No this certificate 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1° Inpatient 2 ER/Outpatient 3 DOA : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0041587

Registrar DHMH 17 Rev 1/2001

State

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NOBLE

HELEN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

MAR 0 1 2007

32. Registre Signature

122 SPEER RD CHESTERIONN, MD 21620

State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 25 2007 **Physician EMMA** February BARTON 2:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BRADFORD OAKS NURSING HOME PRINCE GEORGE'S CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JUNE 2 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1□M 21 F VIRGINIA Yrs 579-34-9821 87 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show If a Medical Exactive roust be notified at Yos 2□No Directo MD PRINCE GEORGE UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 U.S.A. 4519 SHERBORN LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2 No Specify ģ Specify: BLACK 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other traumatic. Etementary/Secondary (0-12) 10th Coltege (1-4or 5+) DOMESTIC PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JUDE WALKER EMMA GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4519 SHERBORN LANE UPPER MARLBORO, MD 20772 ORIS WYATT SR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Landover, Md 4 Donation 5 Other (Specify) 3/5/2007 HARMONY CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME M \mathcal{D} 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical Se esn IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🖺 No Day Year 5 Other (specify) the 9 Unknown signed to Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2∰No this certificate 1 ☐ Yes Ž☐ No Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 Yes 2 No death. 2 Accident investigation M Director: , 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospitel within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D19431 02-26-2007 30. Name and address of pers who completed cause of death (ttem 23a) (Type, Print) 11701 Livingston Road # 103 Fort Washington, Maryland 20744 Frank Ryan M.D. 32. Registrar's Signat 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Ronald 03 James Bible 03 07 2157 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS Braddock Campus Cumberland **Allegany** 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/08/1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 220-32-2798 73 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD Allegany Flintstone 1 ☐Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 22601 Gilpin Road, NE 21530 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No 1953 – If Yes, Give Year or Dates: 1957 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ģ Specify. 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Airplane Mechanic 12 should be filed whand Mental Hygies Is marked other the 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be iment of Health and Menta ant: If item 27 is marked jury or other traumatic ev Roxie Price Bible Mabel Frederick Madison 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19007 W. Lynnwood Street, Buckeye, AZ R. Dale Bible / son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) MD Vet. Cem @ Rocky Gap 03/09/2007 Flintstone, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. eclo-404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) this tab Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Examir death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Donknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1□ Yes 2☑No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Hnpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending P 24 hours after death. Ne Funeral Director: After t Certification: After 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36766 (3 F GOSIP HMAN 1-VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Seton Drive, Cumberland, MD Vik Poonai, M.D., 21502 nos

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2007

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			For State Registrar		State of Ma	aryland /		artment <i>tificate</i>			Mental H	ygier Reg. N	7. U (7	08360	
T.	Physic /Medi		1. Decedent's Name (Fir Sara		2. Date Mont Bridges Marc					0)ay 2007	Year	3. Time of Death			
	Examir		4a. Facility Name (If not a 701 Four	. 3	street and number) eet, Apt.	318				location of Death	1	4	c. County			
	Funeral Director		5. Social Security Number 217–28–9096	6 10	7. Ag	e (In yrs. last b 74	irthday) Yrs.	If Under 1 Months		If Under 24 Hrs. Hours Min.	8. Date of E (Month, 1	Day, Yea	1		place (State or Foreign htty) sylvania	
	aryland ehow nd at	2		o. County		10c. City, Tov									0d. Inside City Limits	
	h with the M 13a or 28a-1 11 be notifie	al Director	MD Allegany Cumberland 10e. Street and Number 701 Fourth Street, Apt. 318									10g. 0	Citizen of V		1 XYes 2 No ntry?	
36	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 X	2 Married	12. Was Decedent Armed Forces? 1 Tes 2 Th If Yes, Give Year or Dates:			Vas Decede Yes, specif		panic Origin? (S Mexican, Puert Specify:	pecify Yes or for Rican, etc.)	No-		ck, White,	ean Indian, etc. nite	
Maryland 21215-0036	within ane. then "	Completed	(Specify or	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker					16b. Kind of Business/Industry		
land 2	be filed ntal Hygi od other event,	To Be Co	17. Father's Name (First, Charles	, Middle, Last)	Henry	Swea	arma			8. Mother's Nar Maude	ne (First, Midd	le, Maide	an Sumam		ner	
_	and and sm	F	19a. Informant's Name/F Linda Shan							Row, M			or Town,		Code)	
Baltimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cre 4 ☐ Donation 5 ☐	emation 3 🗆 R	lemoval from State		ery, crem	atory or oth	er place)	ry 03/0	Date 06/2007		Location -			
Balt	permit. Page Depertment Importent: Il any Injury o		21. Signature of Fureral	r C- 6	Estern		1	104 De	catu	r Stree	t, Cumb	ily erla	Fune	ral I	Home, P.A. 21502	
	Prrysician /Medical Examiner		23a. Part1. Enter the dis shock, or heart failt Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate.	ure. List only or	Due to (or as	a consequence	of):	ar the mode		such as cardiac	or respiratory	arrest,	-= -72		Approximate Interval Between Onset and Death	
68760,	ficate be executed physicien and the stransit is the burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):														
P.O. Box 6	ath certi ttending or use a	Physician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 monti 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	giiaiii	1 ☐ Live birth	f yes, outcome of pregnancy □ Live birth 2 □ Fetat death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)								23d. Date of delivery Month Day Yea		
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant	conditions con	stributing to death bu	ut not resulting i	in the un	derlying cau	se given	in Part I.					ne cause of death? ably 4 Unknown	
al Reco		Completed									24a. Wa aut per 1 Yes	opsy formed?	P	Vere autoportor to confeath?	psy findings available inpletion of cause of	
Division of Vital Records,	To the Hospital or Attending Physicien: The within 24 hours attended to the Cusher Director: Alier this certificate completely filled in by the funeral director, pag	ation: To Be	25. Was case referred to examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Accident	1	28a. Date of Injur	26. Place of Death (Check only one) ospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Company one) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? M 1 Yes 2 No							()			
Divis	tal or Atters after deter deter deter deter deter determent on Director determent of the determinant of the	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	ry - At home, fa :. (Specify)	y - At home, farm, street, factory, office 28f. Locatic					on (Street and Number or Rural Route Number, Town, State)						
	To the Hospital within 24 hours a To the Funerel Completely filled	edical	one)	Medical Examir	sician: To the best of ner: On the basis of and manner sta	examination ar	e, death	estigation, in	my opin	ion, death occur	and due to the red at the time	e cause(e, date ar	s) and mai nd place, a	nner as stand due to	ated. the cause(s)	
)	To To	×	29b. Signature and title o	Sh	Uni ha]	icense r D 175				ate signed		0ay, Year) 007	
	nu			ony J. E	Bollino,	Jr., M.			Vati	onal Hi	ghway,	LaVa	ıle, İ	MD 2	21502	
	Sta Registr		31. Date filed (Month, Da	6 2007	32. Registra	r's Signature	food	18.00								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

February 28,

Dav

Year

2007

Anne Arundel

4c. County of Death

U.S.A.

16b. Kind of Business/Industry

Farming

23d Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

14. Race - American Indian, Black. White, etc.

Black

2:55 ^{A м}

Birthplace (State or Foreign Country)

Maryland

10d. Inside City Limits

Approximate Interval Between Onset and Death

LAG

Yes 2 □ No

PARKWAY

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAR 0 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

DKEOWU DARLY

1. Decedent's Name (First, Middle, Last)

Stanley R. Brown

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner



29c. License number

00051437

Masicar

07-01781 Robert Clark Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Clark		S - For State egistrar	tate of Maryla		artment of artificate of		d Mental F		eg. No.	07 08362
Physician Medical Examine	r	Decedent's Name (First, Midd Robert D.	Clark					2. Date of Dea Month March 6, 2	Day Year	3. Time of Death 0825 hrs
	-	a. Facility Name (if not instituti Peninsula Regional F		umber)		4b. City, Town, or Salisbury	Location of Deal	h	4c. County of Wicomico	
Funeral Director		5. Social Security Number 219-62-8272	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days				Birthplace (State or Foreign Country) PA
Varyland 28a-f show any 1.at once.	1		comico		, Town or Locat	7		-	Og. Citizen of Wha	10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once		Oe. Street and Number 3722 Union Ch				10f. Zip Code 218			U.S.A.	
fter death w		11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Di		2 X No		is Decedent of His es, specify Cuban Yes 2 X No	, Mexican, Puert		5- 14. Race - White, Specify:	American Indian, Black, etc. white
5-0036 6 within 72 hours at tygiene. other than "natural the Medical Examin	ומובובת	15. Decedent's Education (Sp. Elementary/Secondary (0-12 12		de completed) 1-4 or 5+)	during m	nt's Usual Occupat lost of working life. artender			16b. Kind of Bus	iness/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		77. Father's Name (First, Middle Chester H. Cl						ne (First, Middle, e Valent	Maiden Surname)	
e, MD 21215-C 1 and 2 should be filed v 1 end 2 should be filed v Health and Mental High item 27 is marked oth rtraumatic event, the 1 TO Be CC	2	9a. Informant's Name/Relation Robert P. Cla			113	White St	reet	Salisl	mber, City or Town	21804
늘 요성들의		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other S	_	rom State	crematory or ot	sition (Name of cer her place) Memory	3-1	Date 2-2007		City or Town, State
		21. Signature of Funeral Service	Licensee	L	22.	Name and Address Short Fur 3 E. Gro	of Facility neral Ho ove Stre	me et Del	lmar, DE	19940
Physician /M lical Examiner		23a. Part I. Enter the disease, of failure. List only one cause immediate Cause (Final diseasor condition resulting in death)	e on each line. e a. <u>Intrac</u> e		emorrhage	he mode of dying,	such as cardiac	or respiratory arr	rest, shock, or hear	t Approximate Interval Between Onset and Death
a de		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b Due to (or as	a consequence						
outed nd fransit	LYGILL	(Disease or injury that initiated events resulting in death) Last	-0.	a consequence	of):					
60, Ite be executed hysician and e burial - transit		X UNPENDED		PII,27,per		, 3/17/07	T		23d. Date of c	delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Control of the physician To De Completed by the Division To De Completed by the Division of Experimental Control of the Control	lysicially	3b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ur	the 1 Live	birth nant at time of d	2 F6	etal death 3 ther (Specify)	Ectopic pregr	nancy	Month	Day Y ear
P.O. B res that the d signed by the be detached	<u> </u>	Part II. Other significant cond	itions contributing t	to death but not	resulting in the	underlying cause o	given in Part I.			oute to the cause of death? Probably 4 Unknown
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F Vital Rec Physician: The I r this certificate I ral director, page	8 2	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Ll ital	Inpatient 2	ER/Outpatien		of Death (Chec Other Nurs	k only one) ing Home 5	Residence 6	Other:
Vision of Vor Attending Ph. Rer death. Director: After t in by the funeral	ation:	27. Manner of Death 1 X Natural 5 Per	28a. Date (Mont nding estigation	e of Injury th, Day,Year)	28b. Time of	· · · · · · · · · · · · · · · · · · ·	ry at Work? Yes 2 No	28d. Describe	how injury occurre	d
Division or Hospital or Attending 24 hours after death 25 thours After death Director: After stely filled in by the fune	Sertific	3 Suicide 6 Codet	uld not be ermined (Specify)		et, factory, office b		or Town,	State)	r or Rural Route Number, City
Di To the Hospital - within 24 hours a To the Funeral I completely filled	edical	one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	of examination	dge, death occu and/or investiga	ition, in my opinion	, death occurred	nd due to the cau d at the time, date	and place, and du	ue to the cause(s)
	2	29b. Signature and title of certif	D, M.	D		29c. Licens			March 9, 20	d (Month, Day, Year)
		30. Name and address of perso Ling Li, MD Assist	n who completed cau ant Medical Exa			et, Baltimore,	MD 21201			
Stat Registra	.~	31. Date filed (Month, Day, Year	3 2007 32. F	Registrar's Signa		201. 1				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar#31 per wichd/3-2-07/dls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marke 0 Morcesto OCOMO If Under 24 Hrs. Socia Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 2 🗆 F 141-24-1940 Usual Residence of Decedent Yrs Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 □ No 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Iteme 23a Completed by Funeral treat Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1951 If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. 14. Race -1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural', or 1 ☐ Yes 2 KNo Specify 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 17. Father's Name (First, Middle, Last) rosser Worke 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mentai ٥ MOSC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2: Department of Health ar Important: If Item 27 ie eny injury or other trausones. Hrva M. Intah Way incossana Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R

4 Sponation 5 □ Other (Specify) 3 Removal from State Kirdletren C0615 0 22. Name and Address of Facility Bennic 21. Signature o geral Service Smith fun Homo P. O. Box 331 Pocomoke 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** LUNG CANCER METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has b irector, page 2 s 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this Director: After the in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 00062172 3/2/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATYAL, MD 21851 MD MARKET ST. POCOMOICE 1604 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

MAR 0 2 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:05 PM M February 27 2007 anes /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Wicomico Nursing Home Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 □ F 15-20-1209 19-Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show Iner must be notified at 1 ☐ Yes 2 ☐ No Director ri a 100mico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Busines Elementary/Secondary (0-12) College (1-4or 5+) other than 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be is marked ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Hard Md, 2/820 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State Con 4 Donation 5 Dother (Specify) -07 22. Name and Address of Facility 21 Signature of Funeral Service complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. (ja Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVO /Medical Due to (or as a consequence of): Examiner CVA. Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERGYCEMIA 1 Yes 2 No 3 Probably Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 2 N No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes VINO 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760. has been signed by ge 2 should be detact this certificate or Attending Physician: within 24 hours after death. To the Funeral Director: After filled in by the

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

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(Check only one)

Yogesh

31. Date filed (Month

29b. Signature and title of certifier

Whra M.D.

2 0

614 Eastern Dr Salisbury MD 21804

s of person who completed cause of death (Item 23a) (Type, Print)

R gistrar's Signature

leeve

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0063199

29d. Date signed (Month, Day, Year)

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Registrar
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State

31. Date filed (Month, Day,

Year)

32. Registrar's Spnature

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			For State Registrar	State of Ivia	liylaii		tificate of		-	gieili Reg. Ne	ZUUF	08366
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physicia		Harquer	n'to		(arma	ch	Month March 7	Da 7 . 2	ay Year 2007	6:15 A ^M
	/Medic Examin		4a. Facility Name (If not in stitution, give	street and number)				or Location of Death			c. County of Deat	
VÉ.	ZAGITIII		College View Cente	r			Frederic	ck		Fr	ederick	
	Funeral		5. Social Security Number 6. Se		(In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year	9. Birt	thplace (State or Foreign
	Director		214-10-3276 Usual Residence of Decedent	JW 201F	10	3 Yrs.			June 14	, 1	903 Mar	yland
4	2 A	1	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	mary mary	to	Maryland Frederick		Mt.	Airy						1 ☐ Yes 2X No
4	17.28a	Director	10e. Street and Number		110.	11117	10f. Zip Code		T	10g. C	itizen of What Co	ountry?
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1	SE SE	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?		.S. 13.	Was Decedent of I	Hispanic Origin? (Si an, Mexican, Puert	pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, Whit	
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00	tural'	q pa	3 X Widowed 4 □ Divorced 15. Decedent's Edi	Year or Dates:		16a Dece	dent's Usual Occur	nation		16b	WI Kind of Business	nite Undustry
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ק	othe	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle	. Maide	n <i>Sumame</i>)	
/lar	uid be Vental irked o		William Christophe	r Woerner				Mary Jan				
Maryland	permit. Pages 1 and 2 should be filed within 7.2 hours after beath with the marytat Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if time Z? Is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exeminer must be notified at once.		19a. Informant's Name/Relationship (T	/pe, Print)		19b. Maili	ng Address (Street	and Number or Ru	ral Route Numb	er, City	or Town, State, 2	Zip Code)
	ealth m 27 ner tr		Mary Jane Norris,	niece	-			de Road,				
altimore,	ages I nt of H t: if iter f or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. F	lace of Dispo semetery, crea	sition (Name of matory or other pla	ce)	Date	20c. I	Location - City or	Town, State
Ë,	tant:		* 4 ☐ Donation 5 ☐ Other (Specify		Mt		et Cemete		/2007			Maryland
Bal	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Licens	i 00								uneral Home
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			23a. Part . En er the disease, or comp sho th, or leart failure. List only o	ne cause on each lir	16.	n. Do not en	ter the mode or dyn	ng, suon as cardiac	or respiratory a	11030		Interval Between Onset and Death
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Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	Ideath 3	☐Ectopic pregnand ☐ Other (specify)	ÿ.			23d. Date of de Month	livery Day Year
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	requires that the leen signed by th hould be detache	h.	Part II. Other significant conditions co	entributing to death b	ut not res	sutting in the u	inderlying cause gr	ven in Pant.	23e. Did	tobacco	use contribute to	o the cause of death?
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>	<u>v</u> .∞ v	ToB	examiner?	Hospital: 1 Inpatie	nt 2	ER/Outpatie	nt 3 DOA Ot	her: Wursing H	lome 5 ☐ Res	idence	6 □Other (Spe	ecify)
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	or Atl	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, et			reet, factory, office		28f. Location (Street a	an <i>d Number or R</i> ite)	ural Route Number,
		Ce	CO. Continu	alalas Table San	-4			data and place	and due to the		(a) and — annua	
	Hospital	edical		ysician: To the best liner: On the basis of and manner sta	examina							
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	_		30. Name and address of person who	completed cause of c	eath (Ite	m 23a) (Tvpe	Print)					
	3		Hemen Shah	vs. 6	5 0	Thon	nas. Tol	mson b	ov Fr	ede	enic M	D 21702
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death March 12, Physician Lena Marie Costley 12:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6251 Oxon Hill Road Oxon Hill Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sept. 17, 1949 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 😿 F 577-68-5118 57 Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or the marked other than "natural" or the marked other than "natural" or the market of the 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Prince George's 1 ☐ Yes 2 No Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6251 Oxon Hill Road #103 20745 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ Z☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No **Black** Specify. ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Park University Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augustus Jasper Henrietta Thompson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Costley / Husband 6251 Oxon Hill Road #103 Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 03/14/2007 Kalas Crematory 4 Donation 5 Other (Specify) Edgewater, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC BREAST 12/2006 - 3/2007 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, the sequentially list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate performed 1∐ Yes 2XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. within To the 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar Dodyard

8926

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deepharayan

MAR 1 6 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Trenton Elijah Colbert March 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington County Hagerstown 8. Date of Birth (Month, Day, March If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1∰ M 2□ F 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months ^{Year)} 2007 Davs Maryland Hours Director none 31 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ia or 28a-f show t be notified at 10a State 10h County Y Yes 2 □ No Director Maryland Washington Hagersotwn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a 53 East Franklin Street 21740 U.S.A. **Examiner must** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1□Yes 2 No Baltimore, Maryland 21215-0036 'natural", or Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Not Stated Jessica Colbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jessica Colbert (mother) 53 East Franklin St. Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem Park Hagerstown Maryland 3-9-2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Prematuri /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the bunal-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months? 1☐ Yes 2☐ No Month Year 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. þ - bladder 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed death? 2 No 2 No 1☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medic examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ia Uddin, MD 3H-0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 06

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Elva Jane CLEM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner If Under 24 Hrs. 5. Social Security Number 200 3 7. Age (In yrs. last birthday) If Under 1 **Funeral** 6. Sex 8. Date of Birth (Month, Day, 9. Birthpla e (State or Foreign 1 □ M 2 S Days Months Hours Director 86 8 Maryland 214-14-6055 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exercises must be notified at 1 ☐ Yes 🏖 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral Poffenberger Road 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 Specify: White 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", any injury or other traumatic event, the Medical Example. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Davidson Bettie Moats ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Clem - Daughter 128 Sunbrook Lane, Hagerstown, Md. 21742 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ' 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 3/7/07 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home estal 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown the cause of death? þ obably 4

been signed by t should be detach Completed page 2 certificate director. Be 2 Certification: After after death.

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use conf	tribute to
	1 🗆 Yes	2 🗆 No	3 ☐ Pro

25. Was case relerred to medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

24a. Was an autopsy performe 2 No 1 Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No	Но	ospital: 1 Inpatient 2[☐ ER/Outpatient	3 🗆 [OOA
7. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	280

Other: 42 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	1 Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investign and manner stated.	curred at the time, date and place, and due to the gation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
29b. Signature and	d title of contifier	29c. License number	29d. Date signed (Month, Day, Year)

6 Could not be determined

29c. License number U50362 29d. Date signed (Month, Day, Year) March 5,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00H-2 Vincent Cantone 31. Date filed (Month, Day, Year)

3 🗍 Suicide

4 Homicide

22911 Jefferson Blvd.

Smithsburg, Md. 21783

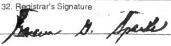
State Registrar

filled in by

completely

Medical

MAR 06 2007



Division or Attending

Hospital within 24 hours a To the Funaral (

To the

			1 - For State Registrar	State	of Mar	yland / Dep <i>Ce</i>		nt of Ho te of D		ind Mei	_	giene Reg. No.	2007	08370
	Physici /Medi		1. Decedent's Name (First, Middle, La Robert Hugh Chri	stie						(Date of De Month 03/02/	07 ^{Day}	Year	3. Time of Death 0116 am M
	Examir	ner	4a. Facility Name (If not institution, gir Atlantic General	Hospit	a1		Ber	Town, or				W	County of Death	r
	Funeral Director		441-46-1385	Sex XIXIM 2□F	7. Age ('In yrs. last birthday Yrs.	Months	Days	If Under 2 Hours	Min. 8.	Date of Birt (Month, Da 12/1/1	940	9. Birth Cou New	place (State or Foreign intry) York
9110	Maryland -f ehow	tor	Usual Residence of Decedent 10a State MD 10b. County Worce	ster	1	Oc. City, Town or L Berlin	ocation							10d. Inside City Limits 1 ☐ Yes 2\(\frac{1}{2}\)No
0	deeth with the Maryland ms 23s or 28s-f show mat be notified at	Funeral Director	10e. Street and Number 5 Drawbridge Rd.				10f. Zi	p Code 2181	L			10g. Citize	en of What Cou	untry?
1900 7 2000 7	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exp. Item must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed For 1 ZYes If Yes, Gi Year or D	orces? 2 □ No ve	er in U.S. 13	Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican, Specity:	in? (Specif Puerto Ric	y Yes or No an, etc.)		4. Race - Amer Black, White Specify: Wh	
27/	within 72 ho ane. than "natur	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		-	(Giv.	B kind of w DO NOT i	ual Occupa ork done di use retired)	uring most	of working tant			d of Business/I	Industry
12 10 39 0 Iand 21	uld be filed Aental Hygie rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last Robert Hugh Chr		SR.		<u> </u>		18. Mother	's Name (F	irst, Middle, e Fen1		Gumame)	
- 12 - 03 Maryland	nd 2 shoi eith and A 27 is ma ir trauma		19a. Informant's Name/Relationship Helen Christie	Type, Print) / Wif	e	19b. Maii 5 Dr	ing Addres awbri	s (Street a. .dge I	nd Number	ror <i>R</i> ural R Berli	oute Numbe	2181	Town, State, Zi	ip Code)
$\frac{\partial \mathcal{O} \mathcal{O}}{\partial \mathcal{O}}$ Baltimore,	Pages 1 e nent of Her ent: if item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			20b. Place of Disp Cape Heni	open	°CY em	1	3/2/20	007		ation - City or I kford,	Own, State DE
l I Balt	permit. Departimporti		21. Signature of un 1 Service Lice	nsee Sun box	2	2					age Fu rlin,		l Home 1811	
•	Physician /Medical Examiner		23a. Pant: Effice the disease, or con shock, or hear failurer List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to immediate	a. Due to	(or as a c	consequence of):		ve~		ardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	vate be executed by sicien and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.		consequence of):								
hrs tie 1385 .0. Box 6	es that the death certificate ligned by the ettending physioned by the ettending physioned detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		ointh 2 i	Fetal death 3	⊒Ectopic p ⊒ Other (s					23	d. Date of deliving Month	very Day Year
T. C	w requires that the been signed by th should be detache	ρ	Part II. Other significant conditions of Sepsis	contributing to d	eath but i	not resulting in the	underlying	cause giver	n in Part I.			obacco use ′es 2□		the cause of death?
bert H. 71-76 tal Record	The law ste hes b page 2 s	Completed		P							1 Tes	med? 2 No	prior to co death?	opsy findings available ompletion of cause of
Ro of Vi	두 후 등	ation: To Be	25. Was case referred to medical examiner? 1	28a. Date (Mon		2 ER/Outpatie 28b. Time of Injury		OA Other 28c. Injury Work	4 🗆 Nur	sing Home 28d	5 Resid	lence 6	Other (Specioccurred	fy)
Division	To the Hospitel of Attending within 24 hours after death. To the Funersi Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	288. Place	of Injury ing, etc. (· At home, farm, si (Specify)	reet, factor	y, office		28f.	Location (S City or Tow	itreet and m, State)	Number or Rui	al Route Number,
	he Hospil n 24 hour he Funer	edical	29a. Certifier (Check only one) Certifying Pl	miner: On the b	best of a asis of ex ner state	my knowledge, dea kamination and/or in d.	th occurred nvestigation	at the time n, in my opi	e, date and nion, death	place, and occurred a	due to the dat the time, d	ause(s) a date and p	nd manner as : lace, and due !	stated. to the cause(s)
	To t To t	2	29b. Signature and title of certifier	Μ.	D.		- 1	c. License		0			signed (Month,	
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*	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 0 5 2	007	egistrar's	s Signature	parle	,						

07-01863 Kathryn Mae Cottrill Unpend #23a,PII,27,28a-f, perME, g866, 4/26/07 TT

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	State of Mar	Vland / Do	nortment of He	alth and Ma	ontal Hygic	200

		1- For State Registrar Certificate of De	ath	Reg	2007	U83/1
Physici Medical Exam	an/ ner	Decedent's Name (First, Middle,Last) Kathryn Mae Cottrill		2. Date of Death	Day Year	3. Time of Death 1307 hrs
			y, Town, or Location of Dea ston	ath	4c. County of Death Talbot	
Funeral Director		215-62-1437 _{1 M 2} XF 52 Yrs. Mo	Inder 1 Year If Under 24H Inths Days Hours M	Alin. 3 – 30 – 1	MM/DD/YYYY) 9. Bird 1 9 5 4 Foreign Con	hplace (State or ੀੜ੍ਹੇston, Md
Maryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. 5980 Newton Road	Zip Code 21655	10g	Citizen of What Cour	ntry?
ter death with	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, spin 1 Yes 2 X No	edent of Hispanic Origin? (edfy Cuban, Mexican, Puer		14. Race - Ameri White, etc. Specify: Whi	
0036 within 72 hours after death with the Maryland yiene. The than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Completed by	or Dates:	ual Occupation (Give kind o working life. DO NOT use r	of work done 1 retired)	6b. Kind of Business/I	
다 를 뜻 를 다	Be Com	17. Father's Name (First, Middle, Last) Walter E. Saunders		me (First, Middle, Ma		p10100
nore, MD 2121 signs I and 2 should be fi to of Health and Montal I. t: If item 27 is marked other traumatic event,	To leave	19a. Informant's Name/Relationship (Type, Print) Husband 19b Mailing Addr. Clarence D. Cottrill (Husba5980 Ne			er, City or Town, State.	Zip Code)
More, ages I arent of Hea		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (rematory or other pla Olivet Cem	Name of cemetery,		20c. Location - City or	
			and Address of Facility Carroll Hur Box 518	ley Fune	eral Home	PC
Physician /Medical Examiner		23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Drowning Due to (or as a consequence of):	le of dying, such as cardi	c or respiratory arrest	, shock, or hear	pproximate in erval Between Onset and Death
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):				
d sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit	Medical E	UNPENDED XX AMENDED #19a,19b per F.H.	,TCHD,03/13/	/07,sbb		
Box 68760, e death certificate but the attending physic ed for use as the but	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	ath 3 Ectopic preg		23d. Date of delivery Month D	ay Year
P.O. B es that the de igned by the			ing cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68: the Hospital or Attending Physician: The law requires that the death certif him 24 hours after death. The retificate has been signed by the attending impletely filled in by the funeral directors, page 2 should be detached for use as it	Completed by			24a. Was an autopsy perform	prior to c ed? death?	copsy findings available completion of cause of
Vital Rysician: 1	a	25. Was case referred to medical examiner? Hospital: 1 Insertion: 2 FR/Outration: 3	26.Place of Death (Chec		esidence 6 Other	
n of V ding Phys a. After thi funcial di	on: To	1 V Yes 2 No 1 Impatient 2 V Envioupatient 3 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 5 Pending Taylor 2 (0 (2007) Taylor 1 1 1 200 and 1 200 and	28c. Injury at Work?	28d Describe how		
Division tal or Atteners after death all Director: led in by the	Certification:	2 X Accident 3 Suicide 4 Homicide Find 3/9/2007 Find 1:00 pm		28f. Location (Street		ral Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, a my opinion, death occurre	and due to the cause(s) and manner as state	ed.
F % F 8	Me		29c. License number O.C.M.E.	1.	9d. Date signed <i>(Mor</i> March 10, 2007	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street	t, Baltimore, MD 212	201		
S Reais	tate trar	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7			

07-01816 Kathleen Anne D	avi	Please	Type of State	or Print i	n Blad and / I	ck Inc Depar	delible tment c	Ink. E	nsui Ith ar	re All (Copies	Are L	egib		n 7	0837
		1- For State Registrar					ificate c				,	5	Reg. N		UI	0007
Physicia Medical Examir		1. Decedent's Name (First Kathleen		Anne		Da	avis					Date of D Month March 7	eath Day	y Year		3. Time of Death 1805 hrs
		4a. Facility Name (if not in 1403 C Sage Lar		e street and n	umber)			4b. City, Belca		r Location	of Death			4c. County of Harford	Death	
Funeral Director		5. Social Security Number 118-50-4068	6. Se	ex M 2 x F	7. Age (st birthday) Yr	Mont	der 1 Yea			8. Date of		1	Foreig	nplace (State or n Mtty) York
any		Usual Residence of Deced			10	Dc. City, T	own or Loca	ation						,,,,,		10d. Inside City Limits
ryland ia-f show	tç.	Maryland I	larfor	rd		Ве	elkamp		p Code				100.0	citizen of Wha	t Coun	1 X Yes 2 No
th the Ma 23a or 28 notified a	al Director	1403C Sage	Lane						2101				Ţ	JSA	Court	uy:
death wit or items?	Funeral	11. Marital Status 1 Never Married 2	Married	12. Was Dec Armed F 1 Yes							gin? (Spec n, Puerto R	cify Yes or I ican, etc.)	No-	White,	etc.	an Indian, Black,
rs after ural", e	ᇫ	3 X Widowed 4 [15. Decedent's Education	_	If Yes, Give Yes	ar		1 1 16a. Decede			specify:		di dono	Iach	Specify:	whi	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Gant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (College (during r	nost of wo	orking life	DO NOT	use retired		R	Retail		a Avenue
altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 7 partment of Health and Mental Hygiene. prortant: If item 27 is marked other than ury or other traumatic event, the Medica		17. Father's Name (First, N					nve	ntory	y Co	ntrol 18 Mother		irst, Middle		en Surname)	LLI	Avenue
121 Id be fi dental I narked event,	o Be	Walter Merc 19a. Informant's Name/Rel		Type Print \			10h Mailie	- Add	. (2)			nn Mat				
AD 2 2 shou h and h 27 is n	Ť	Michael Mer				13								City or Town, NY 1		
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun	ľ	20a. Method of Disposition 1 Burial 2 X Crei	notion 2	Pomoval fr	om State		ace of Dispo ematory or o	sition (Na	me of ce			Date		. Location - C		
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Baltimo permit. Page Department o Important: injury or oth	k	2 Langualure of Funeral S	rvice Licen	9		CFSP	22.	METER 1991 501	Oway Snow	offell THil	eral	Home	Pro	fession	nal	Associatio 1804
Physician /Medical Examiner		23a. Part I. Enter the disea failure. List only one Immediate Cause (Final di or condition resulting in de	ease a.		aused the	osis	o not enter	the mode	of dying	, such as c	ardiac or n	espiratory a	arrest, s	hock, or heart		Approximate Interval Between Cnset and Death
ecuted and transit	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying (oisease or injury that influevents resulting in death)	ause c.	Due to (or as a												
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Division of Vital Records, P.O. Box 68760, rate of tending Physician: The law requires that the death certificate be ex rs after death. al Director: After this certificate has been signed by the attending physician led in by the funeral director, page 2 should be detached for use as the burial	sician/I	IF FEMALE: 23b. Was decedent pregnar past 12 months? 1 Yes 2 No 9 ₩		23c. If yes, 1 Live b	outcome o pirth nant at tim		2 F	etal death ther (Spe	3	Ectopio	c pregnanc	Ey .	2	3d. Date of de Month	elivery Da	ay Year
.O. B nat the d ed by the		Part II. Other significant of	onditions	contributing to		ut not resi	ulting in the	underlying	g cause (given in Pa	art I.	23e. Did	tobacc		_	ne cause of death?
rds, P	leted by											24a. Wa	es 2 s an opsy	24b. We	ere auto	opsy findings available
Reco : The law ficate has	Completed	05 100							20.51	- 10		per 1 🖊 Yes	formed1	? dea	ath? Yes	
/ital	o Be	25. Was case referred to mexaminer? 1 ✓ Yes 2 N	F	lospital:	Inpatient	2 E	R/Outpatien		26.Place	Other	(Check on Nursing I		Resid	dence 6	Other:	Scene
1 of V	⊢t	27. Manner of Death		28a. Date (Month	of Injury , Day,Year)) 2	28b. Time of	Injury		ry at Work	. 1	3d. Describ	e how in	njury occurred	1	
Division of Vital Records, P.O. Box within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for I.	Certification:	2 Accident 3 Suicide 6 4 Homicide	Pending Investigation Could not determined	be 28e. Plac		/ - At hom	ne, farm, stre	et, factory				Bf. Location or Town,		and Number	or Rura	al Route Number, City
bou hou	Medical Ce	29a. Certifier (Check only 1 Certify		an: To the bes	st of my kr of examin											
¥.≱5,8	¥e	29b. Signature and title of	ertifier	and manner s	iaieu.			29		se number				Date signed		th, Day, Year)
	-	30. Name and address of p	erson who	completed caus	se of deat	th (Item 23	3a)		O.C.	IVI.⊏.	_	_	Ma	arch 8, 200		
		Ana Rubio MD.		nt Medical I	Examin	er 11	11 Penn S	Street, E	Baltimo	ore, MD	21201					
Sta Registr		31. Date filed (Month) Pal	(ear) 3 2	2007 32. R	gistrar's	Signature		padi)	,							

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 Рм March 8, 1250 Joan Marie Darragh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ceci1 Elkton 94 River Road 8. Date of Birth (Month, Day, AUG 12, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 💢 F Pennsylvania 69 Director 211-28-2248 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **ehow** 7 is marked other than "netural", or items 23a or 28a-f ebov traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director E1kton Maryland Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21921 94 River Road Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: þ 3 ☐ Widowed 4 ☒ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Technical within Elementary/Secondary (0-12) College (1-4or 5+) nit. Pages 1 end 2 should be filed within entment of Heelth and Mental Hygiene. ortent: If item 27 is marked other ther injury or other traumatic event, the Minjury or other traumatic event, the Minjury or other traumatic event, the Minjury or other traumatic event. Manufacturing Associate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William A. Clarkson Marie Mower 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1171 Appleton Road, Elkton, Maryland 21921 Catherine M. Kempski/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) March 9. West Chester, 1 Buriai 2 Cremation 3 Removal from State permit. Page Depertment of Importent: If any injury of once. R.A. Ferris & Co. Inc. 2007 Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signalure of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician acres. andra c disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to infine unate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DeNo 9 ☐ Unknown Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Unknown 1 Yes 2 🗆 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 | Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 SNatural 2 ☐ Accident 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Injury 1 Tyes 2 🗌 No within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Fo the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9 2007 23 Walain St. El empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 2des 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 3/5/07, MS, Kent Co. Certificate of Death Amended#26, Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Month Year ALBERT EDWIN DEEMER 2007 /Medical MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 05/23/1930 Der 6. Sex 7. Age (In yrs. last birthday) CHESTER KENT 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 76 218-26-7000 MD Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show The Medical Examiner must be notified at MD QUEEN ANNE'S MILLINGTON 1 Yes XXNo Direct 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 22215 RED LION BRANCH ROAD 21651 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) MACHINCIST/MECHANIC MANUFACTURING other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filment of Health and Mental Hant: If Item 27 is marked ott ALBERT EDWIN DEEMER LILA HOPKINS 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY H. DEEMER/WIFE 22215 RED LION BRANCH ROAD, MILLINGTON, MD 21651 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any injury or once. CHESAPEAKE CREMATORY 03/03/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOW, HELFENBEIN AND NEWNAM FUNERAL
130 SPEER ROAD, CHESTERTOWN, MD 21620 HOME, PA arent ellas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASE Physician CORONARY ARTERY 75 years /Medical Due to (or as a consequence of) Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown م this certificete has been signed al director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DISEASE ARTERIAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? res 2 No of Vital is after deam...
rai Director. After this com...
in by the funeral director, pr 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide 5 To the Hospital o within 24 hours at To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

NOBLE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

122 SPEER MO

RD CHESTERIONN MD 21620 32. Registrar's gnature 5 200

D0041587

2007

			Department of Health and N Certificate of Death	Mental Hygien Reg. N	2001 0001
Physici		Decedent's Name (First, Middle, Last) JACK DUBOSE		2. Date of Death Month D 02 27	3. Time of Death 2007 18:58
/Medic Examin		4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL	4b. City, Town, or Location of Death CLINTON	4	Ac. County of Death PRINCE GEORGE
Funeral Director		5. Social Security Number 579-46-3908 6. Sex 1 M 2 F 7. Age (In yrs. last bird) 1 M 2 F 70	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea JUNE 4, 19	
within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow the Madical Examinar must be notilited at	Director	MD PRINCE GEORGE SUITLA	ND		10d. Inside City Limi 1 1 Yes 2 □ N
N with 1		10e. Street and Number 3804 SWANN RD	10f. Zip Code 20746	10g. C	Citizen of What Country? U.S.A.
be filed within 72 hours after death with the Marylan dotheythen "natural", or Items 23a or 28a-f show work. It a Madical Examinar man be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
vithin 72 hounders.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b.	Kind of Business/Industry
e filed al Hygi I other vent, I	To Be Co	12th 17. Father's Name (First, Middle, Last) JACK DUBOSE SR	CARPENTER 18. Mother's Name ANNIE TE	e (First, Middle, Maide	PRIVATE an Surname)
es 1 and 2 should b of Health and Ment filtem 27 is marked r other traumatic		PEGGY DUBOSE/WIFE 380	Mailing Address (Street and Number or Run 04 SWANN RD SUITLAND	MD 20746	
permit. Pages 1 Depertment of H Importent: If its eny injury or ott		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	y, crematory or other place) Y CEMETERY 03-06	6-2007 LA	Location - City or Town, State NDOVER, MD
Deperment of the poor in the p		21. Signature of Funeral Service Licensee	22. Name and Address of Facility JB 7474 LANDOVER RD LA		(A) (C) (C)
ate be hysici the bu	dical Examiner		10 CARIDIAL INFA 11): BY-PASS GRAF 11):	RCTION	Initerval Between Onset and Death
at the death certific by the attending p stached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
w requires that is been signed by should be detail		Part II. Other significant conditions contributing to death but not resulting in			ouse contribute to the cause of death?
	Completed by			24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ding Phys h. After this funeral di	Certification: To Be	27. Manner of Death 1 2 Natural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day Year) In	26. Place of Death patient 3 DOA Other: 4 Nursing Hor me of uproverse Work? M 1 Yes 2 No		
D 0 0 0	ai Certifi	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, fan building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place,	City or Town, Stat	s) and manner as stated
To the Hos within 24 h To the Fur completely	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	/or investigation, in my opinion, death occurred	ed at the time, date an	ate signed (Month, Day, Year)
		30. Name and address of person who complete cause of death (Item 23a) (1			
Stat Registra	te	SONTHERN MARY LAND HOLD TALE 31. Date filed (Month, Day, Year) 32. Registrar's Signature	CENTER. 7503 Sh		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Inf G865 3/22/07 Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Paula Spence David February 27 2007 10:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 303 Switchgrass Court Ourt Upper Marlboro
7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Da Prince George's 5. Social Security 3578 Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ XF Months Days Hours Min Yrs. Director 579-82-3570 Jan. 13, 1965 Jamaica Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If I fem 27 ie marked other then "natural" ---" any injury or other traumatic excess 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Director Maryland_ Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Switchgrass Court 20774 Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married African 1 ☐ Yes 2 No Specity: Specify. 3 ☐ Widowed 4 ☐ Divorced American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) Real Estate Agent Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aston Leonard Spence Olive VanHorne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Switchgrass Ct., Upper Marlboro, MD
of Disposition (Name of Date 20c. Location - City or To Anselm B. David/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/6/2007 Lakemont Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD 21. Signature of Fune ral Service Licensee 22. Name and Address of Facility Stewart Funeral Home onni wan 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer 4001 Benning Rd., NE Wash., DC 20019 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsecuance of): Examiner burial-transit and Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery ate has been signed by the atter page 2 should be detached for u 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ፟ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Pface of Death | Check only one Other: 4 Nursing Home Residence 6 Other (Specify) Hospitaf: 1 | fnpatient 2 | ER/Outpatient 3 | DOA ဥ 1 ☐ Yes 2√∑ No 27. Manner of Death 1 Natural 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 Yes 2 No investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital o within 24 hours aft To the Funerel Di completely filled in

State Registrar (Check only one)

29b. Signature and title of certifie

Divya Verma, M.D. 31. Date filed (Month, Day, Year)
MAR 0 5 2007

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

7525 Greenway Ctr. Dr., #202 32. Registrar's Signature

29c. License number

D52298

29d. Date signed (Month, Day, Year)

March 2, 2007

Greenbelt, MD

07-01738

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michele E. Dotson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3 Time of Death Medical Examiner Month Day March 5, 2007 1032 hrs Michele Elaine Dotson 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Easton Memorial Hospital Talbot 5. Social Security Number If Under 1 Year I f Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday Director Days Hours Min 199-54-9332 1 M 2 X F 35 Yrs 04 - 14 - 1971Country) PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show notified at once. 28a-f show Caroline 1 X Yes 2 No Ridgley death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 12050 School St. Apt #7 21660 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Examiner must be 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married White, etc. 1 Yes ID 21215-0036 2 should be filed within 72 hours after or and Mental Hygiene. 3 Widowed 4 Divorced If Yes, Give Year Specify.Black 1 Yes 2 X No specify: "natural", à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Self Employed (Computer) Scent Sensations 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filed ment of Health and Mental Hy tant: If item 27 is marked of or other traumatic event, the Be Linwood R. Dotson Beatrice Joyce Gwynn ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD Linwood R. Dotson / Father 1630 S. Conestogo St. Philadelphia PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, crematory or other place) X Burial 2 Cremation 3 Removal from State Important: injury or oth 3/14/07 Cokers Cemetery Greensboro, MD Donation 5 Other Specify: Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home mmie 426 E. Dover St. Easton MD23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical Death Cardiac arrhythmia Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED #23a,27.perME, g866. attending physician or use as the burial XUNPENDED 4/21/07 TI death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth signed by the attending be detached for use as Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 V Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, ificate has been si r, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate 1 🗸 Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) director, of Vital Be Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 Other 1 Yes 2 2 No funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division 5 Pending 1 Yes 2 No the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. Location (Street and Number or Rural Route Number, City 3 6 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📈 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 6, 2007 latte 2210 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State

ORIGINAL

Registrar

2007

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** February 28, 2007 6:50 A Richard Joseph Dreszer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert County If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F Director 380-24-8070 78 July 14, 1928 Poland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director MD Calvert County Huntingtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or : any finyry or other traumatte event, the Medical Examiner must be any filury or other traumatte event, the Medical Examiner must be not any finyry or other traumatte event, the Medical Examiner must be any filed to the first must be any filed to the first must be any filed to the first must be any filed to the fi U.S.A. Funeral 110 Walnut Creek Road 20639 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Film Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolph Dreszer Anna Bucholc 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Dreszer (Son) 110 Walnut Creek Road, Huntingtown, Maryland 20639 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 2007 Clinton, Maryland 21. Signature of Fun 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Fibrillation Examiner Sequentially list conditions, if any, leading to immediate cause. Enter trinderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transit Exami neumom. Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has 20 No 1□ Yes 2□No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 Yes 2 No After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1/2 Natural 5 Pending investigation Injury s after dea... al Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shal D 50290 MID

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registra#s Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month EYANS DARRYL 7:50 PM MAR 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) CAROLINA NASH, NORTH 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 43 244-21-5317 Yrs. Director 11/8/1963 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show MD HOWARD **JESSUP** 1 XYes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a or i 8450 DORSEY RUN ROAD 21045 U.S.A. death ' 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status ral", or iten Examiner Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Navy Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 12th CATERER PRIVATE Pages 1 and 2 should be filed ν trment of Health and Mental Hygie rtant: If item 27 is marked other t njury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAMS EVANS CWENDOLYN BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY EVANS/SISTER 818 GOLD ST ROCKY MOUNT N.C. 27804 permit. Pages 1 and Department of Healinportant: If item 2 any injury or other OCCE. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal free 4 Donation 5 Dother (Specify) ROCKY MOUNTIAN N.C. Church Cemetery 3/7/2007 21 Signature of Funer Sorvice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPHC SHOCK 24 HOURS /Medical Due to (or as a consequence of): Examiner HSY ENCEPHALITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ACQUIRED IMMUNE DEFICIENCY SYNDROUE 13 YRS physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ ASPIRATION PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed ACUTE RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy ANEMIA OF CHACONIC DISEASE 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of al or Attending P after death. I Director: After I d in by the funera 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) A. Caluse, m.D. D64220 MAR. 3,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 CEDAR LANE, COLUMBIA, MD 21044 / JUAN CABRERA, M.D. 32. Registrar's Signature State

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Registrar

DHMH 17 Rev 1/2001

Amended 19a.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** OISTAM EVELYN EVERSOLE 0 04 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner RETIREMENT
6. Sex 7. Age (In WASH INGTON WILLIAMSPORT MO HOME WEED CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🛛 F 95 Director 214-09-4798 June 27 1911 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified 1 Yes 2 □ No Director Maryland Washington Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ò pe or items 23a 16505 Virginia Avenue must USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 □ Divorced White 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Her own home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other I any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Robert George Frye Alice Gladys Hickman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Frye - Nephew 167 Drewery Lane Falling Waters, W. Va. 25419 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/8/07 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA SEVERAL YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 3 Probably 4 Unknown 1 Tyes 2 No Completed DEGENERATINE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy **Division or Vital** 2 No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA မှ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after d e Funeral Direct letely filled in by 4 ☐ Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar STRAYSS

MAR 0 6 2007

31. Date filed (Month, Day, Year)

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HAGERSTOWN

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			30. Name and address of person	who completes cause of d	eath (Itom 0	Ra) /Tuno f				IME	rch 1,	2007	
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			Wilson Health	Care Cente	er	Gait	hersburg	g	Montgomery		
	Funeral Director		5. Social Security Number 131-09-2811	6. Sex 1 □ M 2 🗓 F	Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hi	s. 8. Date of Bir (Month, Da Sept.		. Birthplace (State or Foreign Country) NC	
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	postion				1011 : 1 0: 1: :	
	faryla shov	ō	MD MOntgo	moru		ithersbu	5 0			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
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	death ms 2	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		(Specify Yes or No		American Indian,	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or tems 23a or 28a-f show he Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marrie 3 🌠 Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 ▼ If Yes, Give Year or Dates	No	If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	an, Mexican, Pue Specify:	erto Rican, etc.)		White, etc. White	
2-0	72 ho natur lical 6	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occup	oation	and the	16b. Kind of Busir	ess/Industry	
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	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		20c. Location - Cit								
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. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	4☐Pregnant:	2 Fetal death 3	Ectopic pregnancy Other <i>(specify)</i>	<u>'</u>		23d. Date o Month		
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 X Certifying (Check only one) 2 ☐ Medical Ex	Physician: To the best caminer: On the basis and manner s	it of my knowledge, death of examination and/or instated.	occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)	
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	2		30. Name and address of person w			Print)					
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	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 2007	32. Regist	trar's Signature	,					

State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** $20^{9}0^{7}$ MARCH HOBART MARVIN FRIAR 6:20 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Hospital Leonardtown Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F Director 79 Yrs 305-24-7360 09/26/1927 Indiana Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits ret', or items 23a or 28a-f show Exeminer must be notified at Director 1 ☐ Yes 2 No Indiana Delaware Muncie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4501 North Wheeling Avenue 7B-102 Completed by Funeral 47304 United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "naturet", or 1 ☐ Yes 2 ☑ No Specify 3 Nidowed 4 Divorced White of Health and Mental Hygiene. Item 27 is marked other then "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Retail Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hobart Mckinley Friar Laone Marguett Rife 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joette Ruddick/ Daughter 22061 St. Elizabeth Court, Great Mills, MD 20634 coe of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages of Deportment of Hisportant: If its any njury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cr. 03-05-2007 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reph Shock 1795 /Medical Due to (or as a consequence of): Examiner 5 PIDENTE! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit seph cemix 12675 Due to (or as a consequence of): MARVIN FRIAR Vital Records, P.O. Box 68760, YUGES EMPH y sema Severe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Botien Enersy malnytrihow Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 X No 1 Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DVISTAYZE March 3, 2007 D61719 30. Name a d address of person who completed cause of death (Item 23a) (Type, Print) HOLLYWOOD MARYLAND 20636 DHANANJAY V BHAVSAR 31. Date filed (Month, Day, Year) Megistrar's Signature State

DHMH 17 Rev 1/200

Registrar

MAR 0 5

2007

HOBART

Douglas Wayne Flowers State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death **Medical Examiner** DOUGLAS WAYNE FLOWERS 1539 hrs March 5, 2007 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death 205 Ellicott Drive Queen Anne's Chester 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birtholace (State or **Funeral** oreign Country) MD Days Months Hours Director 222-50-8447 38 08/04/1968 1 X M 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits QUEEN ANNE'S CHESTER 1 Yes 2 X No s 23a or 28a-f show e notified at once. 28a-f show the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 ELLICOTT DRIVE 21619 ä more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with 1 rent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black or items must be Armed Forces 1 X Never Married 2 Married White, etc. Yes 2 X No WHITE Yes 2 X No specify: Widowed Divorced f Yes, Give Year Specify: event, the Medical Examiner "natural", ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) men of Health and Mental Hygiene.
tant: If item 27 is marked other than '
or other traumatic event, the Medical DISABLED 9 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MORGAN FLOWERS, JR. SUSAN REBECCA POWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN R. FLOWERS/MOTHER 209 CRANE STREET, MILLINGTON, MD 21651 20a Method of Disposition 20b. Place of Disposition (Name of cemetery. 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MILLINGTON ASBURY 03/11/2007 MILLINGTON, MD Donation 5 Other Specify FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Death Mixed drug intoxication (cocaine and methadone) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit cal X UNPENDED the attending physician ed for use as the burial -AMENDED, 27,28a-f, perME, g865, 3/23/07 TT certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) After this certificate has been signed by the atte funeral director, page 2 should be detached for t 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 2 No Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Inpatient 2 Other | Nursing Home | 5 | Residence | 6 | Other Scene ER/Outpatient 3 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Division Natural 1 Yes 2 X No Pending Fnd 3/5/2007 Funeral Director: tely filled in by the Fnd 3:28 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide State) or Town, State) 205 Ellicott Dr. Chester. MD determined (Specify) found in residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 6, 2007 O.C.M.E. 1613 Jua Liet 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Mooth Day You MAR) egistrar's Signature 2007 Registrar

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	\\\ Sta	te.	31. Date filed (Month DR Year) 5 20	TUSSA	in 1	95	7.0	DR	ve	trede	rick,	119	211	02
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** C 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1.6 Marko If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, 5. Social Security Number Birthplace (Stete or Foreign Country) Funeral Days Hours Min Year) 889 1 M 2 TF 76-Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic avent, the Medical Exam in an injury by collective callified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director Ke 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Treet 12. Was Decedent Ever in U.S. Armed Forces?

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1 Yes 2 No 24a. Was an certificate has autopsy perform 2 X No 1 Yes uneral director, Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Director: the f 2 Accident 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital hilled Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

			For State	State of Marylan		artment of H			jiene leg. No. 2017	02229
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<u>E</u>	Page nent d ant: If ury or		1 ☐ Burial 2 K ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)	emoval from State		matory	1	3-2007 V	Waldorf, MD	
Baltimore,	permit. Pages 1 and in Department of Health Important: If item 27 any injury or other trange.		21. Signature of Funeral Service License	M00053	- 1	. Name and Addres			old Washing	
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P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other <i>(specify)</i>			23d. Date of deli Month	ivery Day Year
	uires that the signed by do be detact		Part II. Other significant conditions con	tributing to death but not resu	ılting in the uı	nderlying cause give	en in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
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/ita	Physician: r this certifica ral director, I	Be C	25. Was case referred to medical examiner?					eath (Check only on	7 7	
7	hysio this co al dire	ဠ	1 □ Yes 2 No		ER/Outpatien		4 Linuising		ence 6 Other (Spec	cify)
n C	Jing F	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Dáte of Injury (Month, Day Year)	28b. Time of Injury	Worl	y at <br Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division	I or Attending after death. Director; After I in by the funer	licat	Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At ho	me, farm, str		163 2 140	28f. Location (St	treet and Number or Ru	ural Route Number
<u>S</u>	after after Dire	ertil	4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	1)			City or Town	n, State)	, a riogio riambon
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1X Certifying Phys	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the c curred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License			9d. Date signed (Monti	h, Day, Year)
			DX.			0	006h80	1	3/2/1	gagaean Miles
7	2.12.1	n.	30. Name and address of person who co		23a) (Type,	Print) 7501 C	22++2 D-1	Cuit-	207 (1:-+	on MD 20721
D	D1041	4	21 Date filed (Month Man Your)	22 Red trar's Signa	ture ,	1301 20ry	alts Ka	., Suite	ou/, clint	on, MD 2073
	Sta Registi		31. Date filed (Month, MAR ^{ar}) 5	2007	K.	Cores .				
DH	MH 17 Rev 1/2				-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** Jessie Reynolds Gran 2007 12:55 a February 28, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 8918 Owings Harmony If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Hours 1 □ M 2X F May 9, 409-26-4943 87 Tennessee Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8918 Court 20736 U.S.A. Harmony 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specify: Specify: white Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) congressional assistant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Reynolds Nell Trammel ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7237 Deer Lake Lane, Derwood, MD 20855 William S. Gran, Jr., son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens 03/05/07 Dunkirk, MD 22. Name and Address of Facility Sign II Funeral Service License Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause Metastatic Morriman cest lung concer skeletal netrotros 5 mmes disease or condition resulting in death) Due to (or as a consequence of): 19 marths Marsimal cert have care or Examiner Physician/Medical þ Completed Be 10

Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Director;

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence)	uence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ ✔ ¶ o 9 ☐ Unknown	23c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of confidence of the	al death 3 □Ectopic	pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	g cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed' 1∐ Yes 2 ☑	
25. Was case referred to medical examiner?				eath (Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	DOA Other: 4 Nursing	Home 5 Hesidence	6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, factory)	ory, office	and Number or Rural Route Number, ate)	
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and plation, in my opinion, death or	ace, and due to the cause courred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	2	29c. License number	29d. I	Date signed (Month, Day, Year)	
- 22016		D56074	l í	Ebure 28 7007	

DHMH 17 Rev 1/2001

within 24 hours aft

To the Funeral Di

completely filled in

Certification:

Medical

State

Registrar

110 Hospital Road Sude 110

32. Registra Signature

Prince Frederick MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth L. Abboth

MAR

31. Date filed (Month, Day, Year)

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			1 = For State Registrar	Otato of Maryto	-	rtificate of			2 0 0 7	08391
	.P 98	38)	Decedent's Name (First, Middle	, Last)				2. Date of Deat	h	3. Time of Death
H	Physic/Medi		ROBERT EZEKI	EL GREEN				Month February	27, 2007	7:40 A M
1	Exami		4a. Facility Name (If not institution			4b. City, Town, o	or Location of De		4c. County of De	
			WASHINGTON ADV	ENTIST HOSPITAL		Takoma	Park		Montgome	
100	Funeral		5. Social Security Number 247-70-3405	184 105	s. last birthday, Yrs.	Months Days			Year) 9. B	irthplace (State or Foreign Country)
250	Director	-	Usual Residence of Decedent	¹ X ^{M 2□ F} 64	113.			09/18/19	42 Sum	ter S.C.
	yland		10a. State 10b. County		City, Town or L	ocation				10d. Inside City Limits
	a-fat	tor	MD Prince	George's Ft.	Washi	ngton				1. Yes 2 □ No
	or 28	Oire	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What C	Country?
	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examiner roust by notified at	Funeral Director	10614 Cedarwood	Lane		20	744		USA	
	er dez	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1.	U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced		-70	1□Yes 2X No	Specify:		Specif B 1a	ck
21215-0036	72 hours "natural", viral Ex	be	15. Decedent		16a, Dece	dent's Usual Occur	pation		16b, Kind of Busines	s/Industry
215	within 72 ene. then no	pie	(Specify only highes Elementary/Secondary (0-12)	Colfege (1-4or 5+)	(Give	kind of work done DO NOT use retire Caster	during most of ward)	vorking		,
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yla	2 should be filed and Mental Hygis is marked other aumatic event, the	10		Green			Angelin	ne :	Major	
Nar			19a. Informant's Name/Relationsh					Rural Route Number,		
e,	1 an Heal em 2 ther		Bessie Green - 20a. Method of Disposition		Place of Dispo	osition (Name of		Ft. Washi	ngton MD 20c. Location - City of	
ğ	0 0 == =		X Burial 2 ☐ Cremation		anmoton: are	matory or other pla am Vet. Cei	(CO)	CI	heltenham	
Baltimore,	permit. Pag Department Important: i any injury o		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service J.		2	2 Name and Addre	m. '03/	06/2007 Cope Funer		Tial y Laire
B	Ded of the part of		Sotrull					Forestvi		and 20747
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	Pnysician	١,	fmmediate Cause (Fina disease or condition	mily one cause on each line.		A.	0.00	1		friterval Between Onset and Death
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687	ficate p physics ts the t	Physician/Medical		σ.						
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	res that the de signed by the a be detached to	by F	Part II. Other significant condition	s contributing to death but not re	sulting in the u	inderlying cause giv	ven in Part I.			to the cause of death?
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<u> </u>	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:		. Он		eath Check only one	/	
ō	Phys r this ral dii	٠ <u>۲</u>	1 ☐ Yes 2 🗵 No 27. Manner of Death	1 Laginpatient 2	ER/Outpatier		4 Nursing	Home 5 Resider		ecify)
on	Attending Ir death. ctor: After by the funer	tion	1 Maturaf 5 ☐ Pending 2 ☐ Accident investig		Injury	Wo	rk? Yes 2∐No	28d. Describe not	w injury occurred	
	i or Attend after death Director: A	ifica	3 Suicide 6 Could n	ot be 28e. Place of Injury - At	home, farm, st		-	28f. Location (Stre	eet and Number or F	Rural Route Number,
	safe safte el Dir	Certification:	4 Homicide	building, etc. (Spec	city)			City or Town,	State)	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier 1 Certifying	Physician: To the best of my ki	nowledge, deat	h occurred at the til	me, date and pla	ce, and due to the car	use(s) and manner a	is stated.
	the H hin 24 the F mplete	ledi		and manner stated.	Tation and/or in			curred at the time, da	te and place, and du	e to the cause(s)
	To the to the comp	Σ	29b Signature and title of certifier	5 ()	in 1	29c. Licens	se number	29	d. Date signed (Mor	oth, Day, Year)
^	011				X		7 7 00 6	1 01 5	2-20	/
4	8/16		Name and ddress of person v	tho completed cause of death (Le	m 23 Type,	Print) Dpin	der Sir	igh M.D.	e mp	20715
350	Sta	te.	31. Date filed (Month, Day Year)	32. Registrar's Sign	naturate		1 - /	V_JU = 0,		
	Doctor.		MAR 0 5 2007	Ka A	Might	,				

			1 - For State Registrar	State of I	Maryland		artment of H tificate of L		nd Me		ene)7	08392
	D1		1. Decedent's Name (First, Middle, L	.ast)						2. Date of Death Month	Day	Year	3. Time of Death
			Luke Christoph	er Hannon						2 ,		2007	3:50a [™]
			4a. Facility Name (If not institution, g				4b. City, Town, or	Location of	Death		4c. County	of Death	
			Atlantic General 5. Social Security Number 6.		a.1 Age (In yrs. Ia:	od bieth days)	Berlin If Under 1 Year	If Under 2	4 Hre	8. Date of Birth	Worcester		
			102-22-8323	13€ M 2 ☐ F	76	Yrs.	Months Days	Hours	Min.	(Month, Day,	Year)	Cour	lace (State or Foreign etry)
			Usual Residence of Decedent							6 27	1930	NY	
	how		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	Ba-f-	cto	MD Worce:	ster	Ве	rlin							1 ☐ Yes 2Ã No
	ith th	Dire	10e. Street and Number				10f. Zip Code			10	g. Citizen of \	What Cour	ntry?
	23e	ral	1 Harpoon RD	T		1	21811				USA		
	in de	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede	s?	. 13.	Vas Decedent of His f Yes, specify Cubar	spanic Origi n, Mexican,	in? (Spec Puerto R	cify Yes or No- lican, etc.)		e - Americ ck, White,	
36	il', or	by F	3 Widowed 4 Divorced	1 ∐ Yes 20 If Yes, Give Year or Date			☐ Yes 🎎 No	Specify:			Specify	. Wh:	ite
9	2 hou	ted	15. Decedent's	Education		16a. Deced	ent's Usual Occupa	ition		11	6b. Kind of Bu		
215	B. Par	ple	(Specify only highest g	rade completed) College (1-4)	or 5+)	life. l	kind of work done d OO NOT use retired)	uring most o	of workin	g			
2	or th	Con	12			Di:	spatcher				Telep	hone	Company
Ind	d oth	Be	17. Father's Name (First, Middle, Las					18. Mother	's Name	(First, Middle, M.	aiden Suman	10)	
<u></u> ₹	he Hospital or Attending Physicien: The law requires that the death certificate be executed in 24 hours after death. The Funeral Director: After this certificate hes been signed by the attending physicien and placety filled in by the funeral director, page 2 should be detached for use as the burial-transit of placety filled in by the funeral director, page 2 should be detached for use as the burial-transit of placety filled in by the funeral force of the function of the funeral force of the function of the function of the function of the function of the function of the function of the function of the function of the funeral function of the function of the funeral function	2	Luke Joseph Hann							ine Thom			
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	1 and Healt em 2		Marie Hannon (wi	LIE)	20b, Pla		poon RD, sition (Name of	Berli	in, N		Oc. Location -	City or To	own State
пōг	ermit. Pages epartment of nportent: If It ny Injury or o nce.		1 ☐ Buriai 2 ☐ Cremation 3		te cen	netery, cren	open Crei				14.77		
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9 x	certif ding	/Me	IF FEMALE:	23c. If yes, outcor	ne of pregnanc	cv					22d Day	te of delive	
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o.	the d yy the achec	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow									
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rds	quire an sig uld b									1 ☐ Yes	2 □ No	3 ☐ Prob	ably 4 Unknown
SCO	aw re	plet								24a. Was an	24b. \	Were auto	psy findings available
Ä	The I	E								autopsy performe	ed?	death?	noletion of cause of
ita	artifica ctor.	Be	25. Was case referred to medical examiner?	[20]				26. Place o	of Death	Check only one			
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isio	ttend death tor: / the f	cat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be Go Disease	Inium. At hom			es 2 □ No		1 1 (Ct	-4 - 18/ 1		
Division	after after Direction by	ert	4 Homicide determine	d 289. Place of building,	etc. (Specify)	ie, tarm, stre	eet, factory, office		28	If. Location (Stre City or Town,		er or Hura	l Houle Number,
_	spital ours neral filled		29a, Certifier 1 Certifying F	Physician: To the be	st of my knowl	edge, death	occurred at the time	e date and	niace an	nd due to the cau	se(s) and ma	nner as st	atad
	P Ho	edical	one) Z Medicai Exi	aminer: On the basis and manner	of examination	n and/or inv	estigation, in my op	nion, death	occurred	at the time, date	e and place,	and due to	the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier		6		29c. License	number	-	290	I. Date signed	1 (Month, I	Day, Year)
			1 African	roms	freem	m	114	18/3	0		. / < 1	07	
	62	Ī	30. Name and address of person who	o completed cause of	death (ftem 3	(3a) (Type,	Print)				10		
:/	20		Jeffrey Thon	nas Gree	nwood	9	133 H	eal thin	my (Jour	Berl.	WMI	0 21811
	Sta		31. Date filed (Month, Day, Year)	2007 32. R/gi	strar's Signatu	K A	parte		0				
	Registr	al	MAR 0 5	2007	We I	17	et dia						

1-	For State Registrar
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			1 - State Registrar		C	ertific	ate of I	Death			Reg. No	UI	100393
	Physici	an.	1. Decedent's Name (First, Middle, Las	t)	-					2. Date of De Month	Day	Year	3. Time of Death
	Physici /Medic		Donald Herbe	rt Hoover						March	5, 20	07	1:40 Pm
	Examir	er	4a. Facility Name (If not institution, give				ity, Town, or					y of Death	
			901 Bernoudy 1 5. Social Security Number 6. Se		yrs. last birthda		hite	If Under		8. Date of Bir	Balt		
	Funeral Director			ŽM 2□ F 7		Mont		Hours	Min.	Month, Da Aug. 20	y, Year) 1929	Mai	place (State or Foreign intry) Cyland
	D		Usual Residence of Decedent										
	arylar show	_	10a. State 10b. County		c. City, Town or								10d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Director	MD Baltimo	ore	White						40. 011	14040	
	with t		10e. Street and Number 901 Bernoudy 1	Pop d			Zip Code 21161				10g. Citizen of		intry?
	leath	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 1				igin? (Spec	cify Yes or No Rican, etc.)		S.A.	ican Indian,
٥	after or Iter		1 ☐ Never Married 2 💥 Marned	Armed Forces? 1 ☐ Yes 2 📉 No						Rican, etc.)		ck, White	
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9500-612	within 72 hours after death with the Marylaniene. iene. r then "neturel", or Items 23a or 28a-f show the Medical Examiner must be natilised as	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(G	ive kind of	Isual Occup work done	during most	t of workin	g	16b. Kind of B		County
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מ	Hyg Hyg ent,	ပိ	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden Suma		
yland	Mental Mental Med o	To Be	Benjamin H. H	oover				Edr	na F	rey			
ary	nd 2 should lith and Men 27 is marke r traumatic	_	19a. Informant's Name/Relationship (7	ype, Print)	19b. Ma	ailing Addı	ess (Street a	and Numbe	er or Rural	Route Number	er, City or Town	, State, Zi	p Code)
Σ	and 2 ealth n 27 I		Sallye A. Hoo					ly Ro			Hall,		
saltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 ØBurial 2 □ Cremation 3 Ø	Removal from State		rematory	or other plac	1.1	Marc	h9.	20c. Location		
	tment: tant:		*4 □Donation 5 □Other (Specify		Mountvi			ry	2007		Mount		
g	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	I Seuna									tuary,Inc A 17349
			23a. Part 1. Enter the disease, or comp	lications that caused the	death. Do not		Commission of the Commission o					(, P)	Approximate
	Dhualaian		Immediate Cause (Final	ane Guse in each line.				1.				_	Interval Between Onset and Death
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	Examiner		Conservation to the second follows	b									
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5	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C									
å,	be ex ician burial	al E	4	Due to (or as a co	insequence oi):								
68/60 ,	certificate be executed ding physician and ise as the burial-transit	edical	_	d									
X		/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy						23d. D	ate of deliv	rery
ň	w requires that the death been signed by the atten should be detached for u	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		3 ∐Ectopi 5 □ Other	c pregnancy (specify)				М	onth	Day Year
ָ כ	requires that the leen signed by th hould be detache	hysi	9 Unknown	9 Unknown									
s S	es tha	by P	Part II. Other significant conditions co	intributing to death but n	ot resulting in the	e underlyir	ig cause give	en in Part I.			_		the cause of death?
ecords	requir een s hould	eted					·			101	/es 2□No	3 ☐ Pro	bably 4 Unknown
zec C	23 8	ompleted								24a. Was autop		Were aut prior to co death?	opsy findings available empletion of cause of
VITALIN	Th ate pag	O								1 ☐ Yes	2 No	1 🗆 Yes	2 No
<u> </u>	Physicien: this certificantal director,	o Be	25. Was case referred to medical examiner? Yes 2 \sum No	Hospital:	2 ER/Outpat	tiont 3	DOA Othe	00		(Check only o	<i>ne)</i> Jence 6 □Ot	or (Coos	***
ō	g Ph er th eral	1-	27. Manner of Death	28a. Date of Injury (Month, Day Ye		e of	28c. Injury Work				now injury occu		19)
0	Attending Ph ir death. ector: Atter th by the funeral	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 16	a <i>r)</i> Injur	М		Yes 2 🗆 I	No				
UNISION	r Atte er de recto	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S		street, fac	tory, office		. 21	8f. Location (S City or Tox		ber or Rui	al Route Number,
ב	vital o urs aft ral Di	O											
	To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	edical	29a. Certifier Certifying Phy (Check only one)	rsician: To the best of manner: On the basis of exa	amination and/or	ath occur investigat	red at the timition, in my of	ne, date and pinion, deal	d place, ar th occurre	d at the time,	date and place.	and due	o the cause(s)
	o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	and manner stated			29c. License	number			29d. Date signe	ed (Month	Day, Year)
	F ≯ F ŏ	I	I bishruffly MM) Don t	C \1		018	Slob	7	1	Yarch	2(10/-
		10	30. Name and address of person who o	ompleted cause of leath	(Item 23a) (Typ	e, Print)	190	~~			1 .	0,20	
	30		Philip Milite	NO MD 6	Trim	ble	11:14	CT,	Luth	neru:	12 M	n s	1093
	Sta		31. Date filed (Mark) Pay, Year) 200	7 32. Registrar's	Sighature	300					1		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 **, Physician** Month Joseph D. Hurst March 2007 4:25A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Dec. 5, 1 Birthplace (State or Foreign Country) **Funeral** Hours 1**X** M 2□ F 159-12-5299 93 Yrs. 1913 Director Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Directo Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 238 22700 Ridge Road U.S.A. 20876 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Completed by Specify: 3 □ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heating & Elementary/Secondary (0-12) al Hygiene. other than College (1-4or 5+) Estimator Air Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any lighty or other traumatic event ODEs. Be William Lloyd Hurst Elizabeth Couchenour 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda New - Daughter 22700 Ridge Road, Germantown, Maryland 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Irwin Union Cemetery 4 Donation 5 Other (Specify) 3/10/07 Irwin, Pennsylvania 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Frest Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) demontiz **Physician** YCARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a noneequence of): physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the al 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably been si should 1 ∏Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this : After this funeral c 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: , 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1).20148 March 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911 Russell Avenue, Gaithersburg, Maryland 20879 Steven Dolinsky, M.D. 32. Resistrar's Signature State 2007 5 Registrar

		For	1 1040		Marylan	d / Depa	artmen	t of He	ealth a		•	iene	
	1	State Registrar				Cei	rtificate	e of E	Death			eg. No UU	08395
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Funeral		Social Security Nur		. Sex	7. Age (In yrs. I				If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day	9	Birthplace (State or Foreign Country)
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wild be fill Mental Hy arked oth attic even	ם ו	Paul W.										,	
2 should and Me is mark	2 1	Pa. Informant's Nam			-	19b. Mailir	ng Address	(Street al				eatherman ; City or Town, State	
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of Head	-	a. Method of Dispo	sition	☐Removal from S	CE	ace of Dispo	sition (Nam	e of her place) 1		ite	20c. Location - City	
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permit. Pages 1 Department of H important: if ite any injury or ott	2	Signature of Fund	aral Service Lic	ensee			. Name and				12	525 Bradb	ury Ave.
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es that the death certifications that the death certification by the attending phase detached for use as it is the description of the death of the d		FEMALE: 3b. Was decedent p		23c. If yes, outo	ome of pregnath 2 Tetal		Ectopic pre	gnancy				23d. Date of	,
the at	2	in the past 12 m 1 Yes 2 4 9 Unknown			int at time of de		Other (spe					Month	Day Year
that the sed by detacl		rt II. Other signific	ant conditions	contributing to de	ath but not resu	iting in the ur	nderlying ca	usa divar	n in Part I		23e Did tob	pacco use contribute	o to the cause of death?
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w requir been s should											24a. Was a	n 24h Were	autopsy findings available
The law required has been spage 2 should	_										autops	y prior i	to completion of cause of
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ding Physician: h. After this certifica tuneral director.)	examiner?	5	Hospital: 1 🗆 In	patient 2 🗆 E	ER/Outpatien	t_3 🗆 DO	Other	4 □ Nur	rsing Hom	e 5 Deside	nce 6 Other (S	pecify)
ling P After t unera	27	. Manner of Death 1 Aatural	5 Pending		f Injury I, Day Year)	2Bb. Time of Injury		C. Injury	?		3d. Describe ho	w injury occurred	
l or Attending after death. Director: After tin by the funer	5	2 Accident 3 Suicide	investigat	be One Blees	of Injury - At ho	me farm etre	M .		es 2 🗆 N		of Location (St	reet and Number or	Rural Route Number,
Diff o	Ē	4 Homicide	determine	buildin	g, etc. (Specify)	sot, lactory,	Onice		2.0	City or Towr		ridrai Houle Walliber,
		a. Certifier 1 (Check only 2	Certifying I	Physician: To the laminer: On the ha	best of my know	viedge, death	occurred a	t the time	o, date and	d place, an	nd due to the ca	ause(s) and manner ate and place, and d	as stated.
o the Hosp ithin 24 hou o the Fune ompletely fil	29	one)		and manne	er stated.	The of Hill		License				9d. Date signed (Mo	
F 3 F 8		1.	×	1/	4)				1-		- 1	, 22), . 32./
	30	Name and addres	s of person wh	o completed cause	of death (Item	2) 23a) (Type. I		050	362	. "	10	41-13	
9		incent A.	•	ne M.D. 2	2911 Je	effers	,	vd. S	Smith	sbur	g,Md. 2	1783	
State	31	. Date filed (Month,		12. Re	gistrar's Signat	ure Jack							
Registrar	9	MAH	TOTO	O: Section		- 8							

			1- State of Maryland 1tems 23b, d, fper ME, g	/ Depa g 865_e/	rtment of H	ealth a ba th	ind Mental H	ygiene Reg. No2 ()	07 08396		
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of D		Year 2007 6:19 P M		
	/Medic		Kevin Paul Janowsky 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of			ty of Death		
	Examilia		44717 Smith Nursery Road		Hollyw	rood		St.	Mary's		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 14 M 2 F 56	t birthday) _ Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of B Month, D January	irth Pay. Year) 15, 1951	9. Birthplace (State or Foreign Country) New York		
	tand tr		Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Loc	ation				10d. Inside City Limits		
	Mary a-f sh	tor	Maryland St. Mary's Hol	1ywood					1 ☐Yes 2 X No		
	or 28	Director	10e. Street and Number		10f. Zip Code			_	What Country?		
	s 23a	ıral	44717 Smith Nursery Road	T40.14	20636				ISA ace - American Indian,		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No	spanic Origin, Mexican Specify:	jin? (Specify Yes or N , Puerto Rican, etc.)	Bla	ack, White, etc.		
2-0	72 hou natura Ilcal E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	ation	of working	-	Business/Industry		
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Maryland 21215-0036	lid be hental rked o	To Be	Russell Janowsky				ie Hamann				
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altir	mit. P bartme bortan Injur		21. Signature of Funeral Service Licensee	Cemete			6 , 2007 Mattingley-(, Virginia Juneral Home, P.A.		
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8760,	death certificate be executed as a strending physician and dror use as the burial-transit etc.	ical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Dille 1. (2 or a share quents of the conditions) cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.								
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S, D	requires that the een signed by th hould be detache	ρ	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause give	en in Part I.		tobacco use con	ntribute to the cause of death? 3 □ Probably 4 Unknown		
Division or Vital Record	The la ate has page 2	Completed					24a. Wa aut per 1 Yes	opsy formed?	. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
VII.	Physician: Th r this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER	2/Outpatient	3∏ DOA Othe	VE"	of Death (Check only				
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Σį	or Att	in the	3 ☑ Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office ed exhaus	st	28f. Location City or To	(Street and Num own, State) 444	ber or Rural Route Number, 1717 Smith Nurser		
	To the Hospital or Attending Physician: within 24 hours after death: To the Functed Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only one) Medical Examiner: On the basis of examination and manner stated	edge, death	fumes occurred at the timestigation, in my of	ne, date and pinion, deat	place, and due to the occurred at the time	e cause(s) and m	nanner as stated, , and due to the cause(s)		
	o the vithin 2 o the omple	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License	number		29d. Date signe	ed (Month, Day, Year)		
3			· MALATAMO		01	1426	(5	_	-07		
-	77		30. Name and address of person who completed cause of death (Item 2)			T	andtor - M-				
	Sta	te	William D. Boyd, II, M.D. 25365 Po 31. Date filed (Month, Day, Year) 32. Resistrar's Signatur MAR 0 2 2007	EW T	OKOUL KORD	, теопа	ardtown, Mary	Tand 2000	J		
	Registr	7	MAR 0 2 2007	~ 19							

		1 - For State Registrar	State of Marylar			of Health and of Death		jiene	07 0	8397
Physic /Med Exami	ical	Decedent's Name (First, Middle, La Helen JONES Aa. Facility Name (If not institution, giv			4b. City, To	wn, or Location of Dea	2. Date of Dea Month MOMEN	Day 6	Year 3. T	ime of Death
Funeral Director		218-52-5685		last birthday) Yrs.	If Under 1 \	gerstown fear If Under 24 Hr lays Hours Mir		Year)	shington 9. Birthplace (Sountry) Irelan	State or Foreign
paritificates, twat yiation 2.12.13.0000 permit. Pages t and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washin 10e. Street and Number 147 S. Mulberry 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest grade) 12 17. Father's Name (First, Middle, Last Unknown 19a. Informant's Name/Relationship (Granada Fouke — 20a. Method of Disposition 1 Buriel 2 Cremation 3 C 4 Donation 5 Other (Special	Street 12. Was Decedent Ever in U Armed Forces? 1	16a. Dece (Give life. Nurs 19b. Mailir 912 Place of Dispo- cemetery, cre-	gersto 10f. Zip Co 2 Was Decedentif Yes, specify 1 Yes 2X dent's Usual Co kind of work of DO NOT use if es Ass Frede position (Name matory or othe Wn Mem.	1740 t of Hispanic Origin? (Cuban, Mexican, Pue locupation done during most of wetired) 18. Mother's Naunkn treet and Number or Frick Street of replace) Park 3/8	Specify Yes or Norto Rican, etc.) orking ame (First, Middle, OWN Rural Route Number t. Hagers Date / 07	14. R B Spec 16b. Kind of Nursi Maiden Sum. r, City or Tow Stown, 20c. Location	f What Country? JSA ace - American Indiack, White, etc. cify: Whit Business/Industry ing Home ame) m, State, Zip Code Md. 2174 n - City or Town, S town, Ma:	e O tate
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the deal	uence of):	15 E.	Address of Facility Wilson Blv If dying, such as cardi		town,	Maryland Apprinten	21740 eximate and Berein to and Death to and Death to and Death to and Death to an exist and Death to an exis
Physicien: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	al déath 3 [death 5 [□Ectopic pregi □ Other (speci	fy)		N	Date of delivery Month Day	Year
Tecology, The law requires the tenes been signed age 2 should be de	Completed by	Part II. Other significant conditions	continbuting to death but not res	sulting in the u	nderlying cau:	se given in Part I.	24a. Was a autop: perfor	es 2 No	3 Probably . Were autopsy fir prior to completind death? 1 Yes 2 N	4 Unknown
	Certification: To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined.	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c	Other: 4 Nursing Injury at Work? 1 Yes 2 No	Home SE Resid	ence 6 Co	Other (Specify)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alte completely filled in by the fune.	Medical Cert	29a. Certifier Certifying Pl	nysician: To the best of my kniminer: On the basis of examination and manner stated.	owledge, deat	vestigation, in	the time, date and pla my opinion, death oc icense number	ce, and due to the courred at the time, of	cause(s) and late and place	manner as stated. e, and due to the coned (Month, Day, N	
	ate	30. Name and address of person who all the state of the s	completed cause of death (Itel	30	Print) OPAL	04647 - (T. jt)	3 orgenst	Manc	h 5,	2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** P^{M} Linda Marie Kimble February 2007 5:07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marley Neck Health & Rehab Center Anne Arundel 9. Birthplace (State or Foreign Country)
37 Ohio 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 278-34-2093 69 1937 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2XINo other traumatic event, the Medical Examiner must be notified Director St. Mary's Marvland Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 39433 Summit Hill Drive USA 20659 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 'natural", or Items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne T. Heikkila Hnknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau William_Kimble/husband 39433 Summit Hill Drive, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 2, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 1605 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Immediate Cause (Final **Physician** uduac disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to lor as a conse wence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mon Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 🛽 🖵 📈 o 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 245. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Warsing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

State

Name and address of person who cou

MAR 0

Registrar

4b. City, Town, or Location of Death

Under 24 Hrs. Hours Min.

Hours

LEONARDTOWN

If Under 1 Year Months Days

7. Age (In yrs. last birthday)

10c. City, Town or Location

86

Day

ST.

MARCH

8. Date of Birth (Month, Day, Year)

MARCH 4,1920

Year

MARY'S

GERMANY

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2 No

2007

4c. County of Death

	D	Sa or 28a-f show State of the S	iner
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Population of Househ and Maryla Division	Department of nearly and western registere. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijuty or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director
Division or Vital Records, P.O. Box 68760,	/N	Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit of the buria	ertification: To Be Completed by Physician/Medical Examiner

HELGA

10a. State

5. Social Security Number

577-44-4984

Usual Residence of Decedent

KRAEMER

22680 CEDAR LANE NUMBER 1329

1 □ M **25**F

4a. Facility Name (If not institution, give street and number)

10b. County

Be Completed by Physician/Medical Examine within 24 hours after death.

To the Funeral Director: After this certificate has been signed by is completely filled in by the funeral director, page 2 should be detact To the Hospital or Attending Physician: Medical Certification: To

	MD S'	T. MARY	'S	LEON	ARDTOW	N							1 Yes 2 □ I
	10e. Street and Numbe	r				10f. Zip Code				10g. Citiz	en of Wh	at Country	y?
	22680 CED	AR LANE	NUMBER 13	329		20650				υ.	s.	A.	
İ	11. Marital Status		12. Was Decedent I Armed Forces?		13. Wa	as Decedent of H 'es, specify Cub	lispanic Orig	gin? (Specif	y Yes or No		4. Race -	American	
	1 Never Married	2 Married	1 ☐ Yes 2 🛣 N			_		i, Fuello nic	Jan, etc.)			White, et	C.
	3 ₩ Widowed 4 □] Divorced	Year or Dates:		1 -	Yes 2√2 No	Specify:				Specify:	WHIT	E
	(Specify o	i. Decedent's Edu only highest grad	de completed)		(Give kit	nt's Usual Occup nd of work done NOT use retire	during most	t of working		16b. Kin	d of Busi	ness/Indu	stry
	Elementary/Seconda	ry (0-12)	College (1-4or 5	·		CLERK				GII	T ST	ORE	
	17. Father's Name (First	st, Middle, Last)					18. Mother	r's Name <i>(F</i>	irst, Middle,	Maiden S	Surname)		
	(UNAVILAB)	LE)					(UNAV	AILAE	BLE)				
	19a. Informant's Name	/Relationship (T	ype. Print)	1	19b. Mailing	Address (Street	and Numbe	er or Rural F	Route Numb	er, City or	Town, S	tate, Zip C	ode)
	NICOLE C.	BELKOV	/ DAUGHTE	R 4	301 H	UMBOLT (COURT	WALDO	RF. M	ARYLA	ND 2	0601	
	20a. Method of Disposit		Damaval from State	20b. Place	e of Dispositi	ion (Name of tory or other pla	i	ARCH Date	e l			ity or Tow	n, State
	4 □ Donation 5 □		Removal from State)	BRINS	FIELD	-ECHOLS	1	200		CHART	OTTF	HAT.	L, MD
	21. Signature of Funera	al Service Licens	190 C A	Company of the last of the las						-ЕСНО	LS E	UNER	AL HOME,
	Hosen	1 Bans	ha John	M006									MD 20622
	23a. Part1. Enter the d	disease, or comp	lications that caused	the death. D							_	Δ	oproximate
	Immediate Cause (Fina		one cause on each lir	1e.		ance	1/	(M	effec	tat	()	, "	nterval Between Inset and Death
	disease or condition resulting in death)	-	a. Due to (or as	2 0000 0000		1111	-V	Cirl	045	1-4	1		
			Due to (or as	a consequent	ce oi).								
	Sequentially list condition		b.	a consequen	us uf).								
	ri any, leading to immed cause. Enter Underlyin Cause (Disease or injur	ng draw											
	that initiated events resulting in death) Last		cDue to (or as	a consequen	ce of):								_
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	IF FEMALE:		23c. If yes, outcome	of programs	,								
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State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 5 2007

The law requires that the death certificate be executed Box 68760, P.O. Division or Vital Records,

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 1:00 Harry Michael Koehler March 5, Α 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17488 River Drive Piney Point St. Mary's If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) February 28,1927 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑**M 2□F 137-20-4635 80 New Jersey Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2/YNo Director Maryland St. Mary's Piney Point 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pe 17488 River Drive 20674 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 朝 Supply Clerk U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emil Koehler ပ Gertrude Walther 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Koehler Forrest / Daughter P.O. Box 1000, Solomons, Maryland 20688 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. George's Catholic Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any Injury or ot 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9, 2007 Valley Lee, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Month. Immediate Cause (Final Mulfisee hutra cerebrol hutastoses **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an eutopsy perform 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred injury 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined To the Hospital within 24 hours a within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifie 29d. Dete signed (Month, Day, Year) March 5, 2007 A15027 nd address of person who completed cause of death (Item 23a) (Type, Print) John W. Roache, M.D. P.O. Box 186, Mechanicsville, Maryland 20659 32. Registrar's Signature 31. Date filed (Month, Dey, Year) Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	State of I	Maryland		artmen rtificat			d Mental	Hygiei Reg.	4007	0 (3401
	Physici	an	1. Decedent's Name (First, Middle, La	ist)	• •					2. Date Monti		Day Yea		ne of Death
	/Medi		Leroy Knox							Febr	uary	27 200	7 1	530 ^M
1	Examir	er	4a. Facility Name (If not institution, given		er)		4b. City,	Town, or	Location of D	eath		4c. County of De	ath	
			2317 Bentonia 5. Social Security Number 6.		Age (In yrs. la	et highday)	If Under		trict	Heights Hrs. 8. Date		Prince		
	Funeral Director			M 2□F	62	Yrs.	Months	Days			h, Day, Ye	ar) (Country)	ate or Foreign arolina
	within 72 hours after death with the Maryland ene. than "natural, or items 23a or 28a-1 ehow ta Mudical Examinar must be notified at		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Insi	de City Limits
	a Mar	tor	Maryland Prince	George's				Dí	etrict	Height	c		1 🔯	Yes 2□No
	or 28	Director	10e. Street and Number				10f. Zip			mergire		Citizen of What (Country?	
	ath w		2317 Benton	ia Court					20747			United		
	er de	Funerai	11. Marital Status	12. Was Decede Armed Force	es?	. 13.	Was Deced I Yes, spec	dent of Hi cify Cuba	ispanic Origin' n, Mexican, P	? (Specify Yes ouerto Rican, etc.	or No- c.)	14. Race - An Black, Wh		ın,
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Date	□No		1 ☐ Yes	2 X No	Specify:			Specify:	Black	
Maryland 21215-0036	thou stura	ed	15. Decedent's E			16a. Deced	ient's Usua	d Occup	ation		16h	. Kind of Busines		
715	n n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)	o. F.)	(Give life.	kind of wor DO NOT us	rk done d se retired	during most of	working	100	. Killa of Basillos	Sindustry	
212	d with giene	E	12th	College (1-4d	01 5+)		Ma	i1 H	andler			Govern	ment	
g	e file al Hy rent.	Be	17. Father's Name (First, Middle, Last)						Name (First, M	iddle, Maid			
ylaı	Ments Ments arked	To	Will.	Armstrong	5					Ann	ie Ma	e Knox		
lar	2 shc and is my	z li	19a. Inlormant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a	and Number o	r Rural Route N	lumber, Cit	y or Town, State,	Zip Code)	
2	and lealth m 27		Kieca Cole/Daug	hter	1001 01	1043	32 Se:	xtan	t Place	. White		ins, MD		
0	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Sta	ite 206. Pla	ce of Dispo	sition (Nan natory or o	ne of DN plac	0em.	Date	20c.	Location - City of	r Town, Sta	te
Baltimore,	t. Pa tmen tant:		4 ☐ Donation 5 ☐ Other (Speci		Ple:				pt. 3/	7/2007		Bowling	Green	, SC
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s 1 ehow any injury or other treumatic event. It a Mudical Experiment must be notified at angle.		21. Signature of Funeral Service Lice	7500	111	22			s of Facility			eral Hon		
			23a. Part 1. Enter the disease, or com	KLUSTUK	had the death	Do not not						sh., DC	20019 Approx	
8760,	Physician /Medical Examiner bub sicien and bub sicien and site privarientansit is the privarientansit.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or b. — Due to (or c.	rdiac A as a conseque as a conseque as a conseque	nce of): ncs ut):	mia						Onset	and Death
P.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 □Fetal d at time of dea	eath 3	Ectopic pro					23d. Date of de Month	elivery Day	Year
rds, F	w requires that been signed I should be det	þ	Part II. Other significant conditions of End Stag	contributing to death e Renal I			nderlying ca	ause give	n in Part I.			o use contribute 2□No 3□F		
Division of Vital Records,	The law requate has been bage 2 should	Completed	Peripher	al Vascul	lar Dis	ease				-	Was an autopsy performed?	prior to death?	completion	ngs available of cause of
ïa	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						26. Place of	Death Check of	5-2-1-7-7			
5	Attending Physician: r death. ector: After this certifice by the funeral director. I	2	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpa		NOutpatien			4 🗆 Nursin			6 □Other (Sp	ecify)	
Ĕ	ding P. h. After I	ë.	27. Manner of Death 1 ⚠ Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury 2 Da <i>y</i> Year) 2	8b. Time of Injury		Bc. Injury Work		28d. Desc	ribe how in	jury occurred		
Sic	tend death tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not b				М		′es 2 □ No					
<u>></u>	2 4 5 5	Certification;	4 Homicide determined	building,	Injury - At hom etc. (Specify)					City o.	r Town, Sta			Number,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in I	edicai	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example	nysician: To the be niner: On the basis and manner	of examination	edge, death n and/or inv	occurred a restigation,	at the tim in my op	e, date and pl inion, death o	ace, and due to ccurred at the t	the cause me, date a	(s) and manner a and place, and du	is stated. e to the cau	se(s)
	To t withi To tl	ž	29b. Signature and title of certifier				-		number		29d. D	Date signed (Mor	ith, Day, Yea	ar)
)	6		1//www		M	.0.	L	00	605	46	3	3/02/2	7	
-	(a)		30. Name and address of person who		f death (Item 2	3a) (Type, I	Print)					+t		
	7		Hema P. Yad		9470 A	Annapo	lis I	Road	, Suite	#315,	Lanha	am, MD	20706	
100	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 5 2007	Security Sec	strar's Signatur	por	,							

			For State Registrar	Stat	e of M	aryland		artment o <i>tificate</i> (lental Hyg	giene leg. No.	007	08408	2
			1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death	1
٠	Physici: /Medic		Susan		Mar	rie		King			March !	5, 2	007	9:00 A	М
	Examin		4a. Facility Name (If not institution	, give street an	d number)			4b. City, Tow	n, or Location	of Death		4c.	County of De	ath	
ı			Beverly Living	Ctr. c	f Cur	nberla	ınd		erland				Alle	gany	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ∑	_		st birthday)		ear If Unde	r 24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Bi	rthplace (State or Fore	ign
	Director		211-12-8960			90	Yrs.				04/02/	1916	Pe	nnsylvania	
	and w		Usual Residence of Decedent 10a. State 10b. County			10c. City,	Town or Lo	cation						10d. Inside City Limi	its
	Manyl f ehc	ō	MD All	egany			Cum	berland	i					1 X Yes 2 □ N	No
	28a-	Director	10e. Street and Number					10f. Zip Co	ie .			10g. Citi:	zen of What C	country?	
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N	filed y Hygie Sther 1		12 17. Father's Name (First, Middle,	Last)				Homema		er's Name	(First, Middle,		OME Sumame)		
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	C1 00 - 65		Marlene S. Tayl			er		e 2 Bo				267			
ຄົ	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition			20b. Pla	ce of Dispo	sition (Name o	f !		Date	20c. Lo	cation - City o	r Town, State	
altimore,			1 XBurial 2 Cremation 4 Donation 5 Other (S		rom State			emorial		03/0	7/2007	Cu	mberla	nd, MD	
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	Α.		23a. Part1. Enter the disease, or shock, or heart failure. List	complications to	hat caused on each li	d the death.	Do not ente						· · · · · · · · · · · · · · · · · · ·	Approximate Interval Between Onset and Death	
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O. Box	at the death certific by the attending parached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo 9 Unknown	1 ☐ L 4 ☐ F	ive birth	of pregnan 2 Fetal of t time of dea	death 3	Ectopic pregn Other (specif				2	3d. Date of de Month	elivery Day Year	
J.	that led by deta		Part II. Other significant condition	ns contributing	to death b	ut not resul	ting in the ur	nderlying cause	given in Part	l.	23e. Did to	bacco u	se contribute	to the cause of death?	
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Vital	Physician: this certific	Be	25. Was case referred to medical examiner?						0.1		(Check only or				
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ב	ding P	ertification;	27. Manner of Sath 1 Deatural 5 Pendin	g	Month, Da	y Year)	28b. Time of Injury		njury at ' Work? 1 □ Yes 2 □		28d. Describe h	ow injury	occurred /		
Division	r Attender death rector:	ical	2 Accident investig	not be	Place of Ini	urv - At hon	ne. farm stre	eet, factory, off			28f. Location (S	treet and	d Number or F	Rural Route Number,	
2	after Dire	ertii	4 Homicide determ	ined	uilding, et	c. (Specify)	,,	301, 1401019, 011			City or Tow	n, State)			
	∴ To the Hospital or Attending within 24 hours after death. ∴ To the Funeral Director: After Ecompletely filled in by the funeral Director.	edical C	29a. Certifier 1 Certifyir (Check only one) 2 Medicel	Exeminer: On t	o the best he basis o manner st	f examination	ledge, death on and/or inv	occurred at three controls of the control of the control of t	e time, date a ny opinion, de	nd place, a	and due to the c ed at the time, c	ause(s) late and	and manner a place, and du	s stated. e to the cause(s)	
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C	(3)		30. Name and address of person	who completed	S 1	1000	o (0	UVIL	ngto	n C	out,	Cu	inberl	,2007 and, Hd 21	502
	Sta	te	31. Date filed (Month, Day, Year)	1	32. Registr	ar's Signatu	re		0						
	Registr	ar	MAR 0 6	2007		w h	re V	series!							

			For State Registrar	State of Ma	aryland / Dep $C\epsilon$	artment of F ertificate of			jiene Reg. No. 2 A A	7 001.03
ľ	Physicia	an	1. Decedent's Name (First, Middle, La		kersh	217	· · · · · · · · · · · · · · · · · · ·	2. Date of Dea Month	ath Day Yea	
	/Medic	al	4a. Facility Name (If not institution, give	e street and number)	Kersn		or Location of Death	MARCH (02, 2007 4c. County of De	0949 M
1	Examin	er	WMHS-Memorial			CUMBERL			ALLEGAN	
	Funeral Director		5. Social Security Number 6. S 151–50–6921	Sex 7. Age	e (In yrs. last birthday 50 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 08/14/	7, _{Year)} 9. E 1956 Ne	Birthplace (State or Foreign Country) W Jersey
	land ow It		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f she	ctor	WV Morg	an	Paw I	Paw				1 □Yes 2 🎇 No
	vith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	leath v ns 23a must	Funeral	192 Elise La	12. Was Decedent B	Ever in U.S. 13.		434 Hispanic Origin? (Sn	ecify Yes or No-	USA 14. Race - Ai	merican Indian,
136	be filed within 72 hours after death with the Maryland Ital Hygiene. Ital death "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	No	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, W Specify:	
12-0036	72 hou natura dicai E	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	edent's Usual Occup	ation during most of work	ina I	16b. Kind of Busines	
7	within sne. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	e kind of work done DO NOT use retire Homemake		9	••	
Q Q	Hygid other ent, th	Be Co	17. Father's Name (First, Middle, Last					e (First, Middle,	Home Maiden Surname)	
/land	2 should be and Mental is marked caranatic ever	To B	William	Burton	Robin	son, Sr.	Arlene		Bail	Ley
Mar	5 # C # 1		19a. Informant's Name/Relationship (Earl Kershaw / h			^{ing Address <i>(Street</i> Elise Lan}			r, City or Town, State 25434	e, Zip Code)
Je,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐	Domeual from State	20b. Place of Disp	osition (Name of ematory or other pla	ce)	Date	20c. Location - City	or Town, State
Saitimor	Page tment tant: if		4 □ Donation 5 □ Other (Speci	fy)	Cumberla	and Crema	tory 03/0		Cumberla	
pa	permit. Pages 1 Department of H important: if ite any injury or ot once.		21. Signatury of Fundal Service Lice	allow					ily Funera cland, MD	21502 P.A.
	VE V		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	nter the mode of dyin	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	a consequence of):	S				Iday
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Τ.	rtificat ng ph) as th	Medi	IF FEMALE:						1	
O. 20X	w requires that the death certificate signed by the attending should be detached for use as	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (spec <i>ify</i>) _	у		23d. Date of o	delivery Day Year
7	that the	Δ.	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause giv	ren in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ecoras,	equires en sign	ed by	Seizure					1 □ Y	es 2□No 3)	Probably 4 Unknown
200	The law re te has bee bage 2 sho	Completed	Lactic Ac	idosis				24a. Was a		autopsy findings available to completion of cause of
	r: The cate h	Con	Acute Ren	al Failu	re			perfor	med? death 2 No 1 ☐ Y	?
	siclan certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ☐ ER/Outpatie	ent 3 DOA Oth	26. Place of Deat			
0	g Phy ter this neral d	\vdash	27. Manner of Death	28a. Date of Injur (Month, Day	ry 28b. Time				ence 6 □Other (S _i ow injury occurred	pecify)
VISION	tendin eath. tor: Af	catio	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	n		M 1 □	Yes 2 □ No			
	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		rry - At home, farm, si c. <i>(Specify)</i>	treet, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and/or i	th occurred at the ti nvestigation, in my	me, date and place, opinion, death occur	and due to the cred at the time, o	cause(s) and manner date and place, and d	as stated. fue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	A	M. D	29c. Licens	e number	2	29d. Date signed (Mo	onth, Day, Year)
			Wisa	sol	۲۰۱۱،۲۲	De	5118	M	ARCH 02,	2007
	nes		30. Name and address of person who Wirasat Hasa				Ne. C.	mberl	and mid	71507
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		10	-in VE+ (c	1000	
	Registr	ar	MAR 0 5 20	11	1 St. F.	SAR S				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #9 Per Fife G865 Mary Jan 1/Department of Health and Mental Hygiene
Certificate of Death Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Stella Koslosky 2007 4:39 P March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Worcester Ocean City 10509 Marlowe Lane 8. Date of Birth (Month, Day, Year) Sept. 25, 1936 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 □ X 70 Director 191-28-2222 PA. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 □Yes 2X No Ocean City MD Worcester Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r US 21842 10509 Marlowe Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Hospital 4+ Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phyllis Oliver Michael Bussacca 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10509 Marlowe Lane, Ocean City, Md. 21842 John T. Koslosky 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If Iter
any injury or oth 1 Burial 2 Cremation 3 ☐Removal from State Cape Henlopen Crem. 03-06-2007 | Frankford, DE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) artiovascolar /Medical Due to (or as a consequence of): Examiner e to (or as a conse unce of) Sequentially list conditions, if any, basing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a P.0. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown this certificate has been siral director, page 2 should ! Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 1∐ Yes 2/2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 212 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home ို 5 Residence 6 Other (Specify) To the Hospita. ...
within 24 hours after death.
To the Funeral Director. After th' 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 □ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Maturi 00

HU053714

29c. License number

29d. Date signed (Month, Day, Year)

67

of person who completed cause of death (Item 23a) (Type, Print)

Franklin De Suk 302 32. Registrar's Signature

MAR 05 2007

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment c ertificate				iene _{eg. Nö.} ()	07	08405
	Dhycini	^-	1. Decedent's Name (First, Middle, Last)				2	2. Date of Deal	th Day	Year	3. Time of Death
	Physici /Medio		EMILY	М.	LY	NCH			FEB.	27	2007	7:00 P M
}	Examir	ier	4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	vn, or Location	of Death		4c. Cour	ty of Death	
			ATLANTIC GENERAL				ERLIN ear If Under	Od Hen a			RCESTE	
н	Funeral Director		5. Social Security Number 6. Se 1 2 1 9 - 1 2 - 4 3 7 7	x ∃M 20X[F 7.Ag	e (In yrs. last birthda 94 Yrs.		ays Hours	Min.	Date of Birth (Month, Day, AY 25,	Year)	Cour	
			Usual Residence of Decedent		71			FL	A1 23,	1912	AALT	YLAND
	nylan how		10a. State 10b. County		10c. City, Town or	_ocation					1	0d. Inside City Limits
	Se-f	cto	DELAWARE SUSSEX		SELB	YVILLE						1 ☐ Yes 2 X No
	or 2	Director	10e. Street and Number			10f. Zip Co	de		1	0g. Citizen o	f What Cour	ntry?
	e 23e	rai	37544 SALTY WAY				9975			US		
	Item Item	Funerai	11. Marital Status 1 ☐ Never Married 2 🕅 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 📉 1		. Was Decedent If Yes, specify	of Hispanic Ori Cuban, Mexicar	igin? (Speci n, Puerto Ri	ty Yes or No- can, etc.)		ace - Americ lack, White,	
38	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X	No Specify:			Spec	eify: WH	ITE
Ö	within 72 hours after deeth with the Maryland ene. than "natural", or iteme 23s or 28e-f ehow ha Madical Examinar musi ba notilied at	Completed	15. Decedent's Edu			edent's Usual O				16b. Kind of	Business/Inc	dustry
21	d within 72 ho piene. r than "netue the Medical	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	ife.	e kind of work d DO NOT use re	etired)	t or working				
121	73 75		9			HOMEMAK]					1 HOME	
and	e d la b	Be	17. Father's Name (First, Middle, Last)		CARLEN				First, Middle, M		,	
Maryland 21215-0036	d 2 should th and Men 7 is marke traumatic	ပ	THOMAS E		GARLEM	ling Address (St		ULA	C.		DAVIS	Codel
Ma	1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1		JAMES R. LYNCH/HUS	•		44 SALT						
ē,	-735		20a. Method of Disposition	• • • • • • • • • • • • • • • • • • • •	20b. Place of Disp		of !	Dat		20c. Location		
Ë			1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	CREMATOR	-		3/1/0	0.7	DELMAF	P. DEL	AWARE
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens	99 /		22. Name and A		100	-	21111111	c, Dil	21,411.11.
<u> </u>	80 2 2 3		W. Bum Bill	2 h. MOI		ASTINGS					E, DE.	19975
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final	igations that caused ne cause on each lir				cardiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a consequence of):	nemorr	age					
	Examiner	1 1			a consequence on.		0					
		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as:	a consequence of).							
	acuter ind transi	Examiner		s								
8760,	cien g	Ē	resulting in death) Last	Due to (or as	a consequence of):						- 1	
87	death certificate be executed e attending physicien and id for use as the burial-transit	dicai		d								
9 x	eath certifi attending p for use as	Physician/Med	IF FEMALE:	3c. If yes, outcome	of pregnancy					224 D		
Вох	death a atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No		2 Fetal death 3	□Ectopic pregna □ Other (specif)				11.5	ate of delive Ionth	Day Year
0	at the de by the a tached	hys	9 Unknown	9□ Unknown								
S, D	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the	underlying cause	e given in Part I.		23e. Did tob	acco use co	ntribute to th	e cause of death?
ord	w require been si should?	ted	recent stroke						1 □ Ye	s 2 🗆 No	3 🗆 Prob	ably 4 Unknown
ec	aw 2 s b	Completed							24a. Was ar	n 24b	. Were autor	psy findings available inpletion of cause of
E .		Co							perform 1 Yes 2	ned?	death?	2 No
ŽĮ.	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	losoital: >			26. Place Other:	of Death (0	Check only one	e)		
ō.	2 0 7	-T	1 Yes 2 No	lospital: Inpatie			4 LI Nu		5 Reside			"
o U	ttending Phy death. stor: After thii r the funeral o	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year) Injury		Injury at Work? 1 ☐ Yes 2 ☐ I		. 50001150110	w milary cooc		
Division of Vital Records,	or Attendated Director:	ertification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, farm, s	treet, factory, off	ice	281	. Location (Sti	reet and Nun	ber or Rura	l Route Number,
Ö	rs after el Dire ed in b	Cert	4 - Hornicide	building, etc	c. (Specify)				City or Town	, State)		
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edicai	29a. Certifier 1 Certifying Physical (Check only one) 1 Medical Exami	sician: To the best oner: On the basis of and manner sta	of my knowledge, dea examination and/or i	th occurred at the	ne time, date an my opinion, dea	d place, and th occurred	d due to the ca at the time, da	use(s) and nate and place	nanner as st	ated. the cause(s)
	To the To the To the Complet	Med	29b. Signature and title of certifier	and manner sta	ileu.	29c. Lic	cense number		29	9d. Date sign	ed (Month, l	Day, Year)
	08		W. van Ean	nond M	D	1	5630	7		0.1	2710	
	Sol	-	30. Name and address of person who co	empleted cause of de	eath (Item 23a) (Type	B :				-		
1	n		J. vah Egmond MD	, Atlautic	General Ho	spital, 9	733 Hea	Hhna	y Drive	, Berliv	1,MD	21811
	Sta Registr		31. Date filed (Madth, Day, Year) MAR 0 1 20	El .	ar's Signature	hardi)						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 4:03 am narch 2007 Roger Lee LINE Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 X M 2 □ F 63 Dec. 31 1943 Maryland Director 214-42-1007 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18810 Eliason Way 21742 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1967-70 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 💢 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 8 0 <u>Mechanic</u> <u>Lawn/Garden</u> n and Mental Hygir 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Henson Line Hattie Mae Campbell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Patricia Ann Line - Wife 18810 Eliason Way, Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Rose Hill Cemetery 3/5/07 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an , page 2 autopsy certificate 2 1 NO Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ☑ No 1 Mpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation or Attending 1 Natural Injury 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D2145 Name and address of person who completed cause of death (Item 23a) (Type, Print) . HAGERSTOWN. MD 21742 WAHERD OAKHILL MO - 12821_ 3H5+1 32. Registrar's Signature 31, Date filed (Mont) State Registrar

ORIGINAL

			1 - For State Registrar	State of Ma	aryland	-	artment r <i>tificate</i>			Mental Hy	giene Reg. No.	2007	0840
	Physicia	an	1. Decedent's Name (First, Middle, Las							2. Date of D		WID 47 0 1	3. Time of Death
	/Medic	cal	Norma Lee		yers		4h Ciby To	un orloos	tion of Death	2	27	200 7 County of Death	
	Examin	ier	4a Facility Name (If not institution, give	DA	Cin	ITER		ISBUR				Jicimic	
	Funeral		5. Social Security Number 6. S	7. Ag	e (In yrs. I	ast birthday)	If Under 1 Months		nder 24 Hrs. urs Min.	8. Date of Bi	rth ay, Year)	9. Birth	nplace (State or Foreig
	Director		235-54-5151 Usual Residence of Decedent	IN ZUAT	72	Yrs.				5/19/	1934	West	t Virginia
	yland how at		10a. State 10b. County		10c. City	, Town or Lo	cation			-			10d. Inside City Limit
	ne Mai 8a-f sl	Director	Maryland Wicomi	20	Sa.	lisbur	*						1 X Yes 2 □ N
	with the	Dire	10e. Street and Number	_			10f. Zip C			:		zen of What Cou USA	untry?
	death ms 23	Funeral	900 Marble Cour	12. Was Decedent	Ever in U.S	S. 13.		.804 nt of Hispani	c Origin? (Sp	pecify Yes or No Rican, etc.)		14. Race - Amer	
2	permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 20a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		If Yes, specif 1 ☐ Yes 2[ecify:	o Rican, etc.)		Black, White	, etc. white
5	72 hou natura Iical E	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usual	Occupation	most of wor	kina	16b. Ki	nd of Business/I	ndustry
7	vithin in the interval in the interval i	mple	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of work DO NOT use			w/g	_		
7	filed v Hygie ther t	CO e	12 17. Father's Name (<i>First, Middle, Last</i>)	2		Dent	al Hyc			ne (First, Middle		nistry Surname)	
0	uld be Aental rked c	To Be	John Wesley Holb	ert				F.	lorenc	e Agnes	Rya	n	
vial y	d 2 sho th and N 7 is ma trauma		19a. Informant's Name/Relationship (7		nd					ral Route Numi		r Town, State, Z 21804	ip Code)
נ נ	Pages 1 and 2 lent of Health a nt: If item 27 is ry or other trai		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name matory or oth	of		Date		ocation - City or	Town, State
	Page ment c ant: If ury or		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specif</i>)				Crema		3/1/	07	Sal	isbury,	MD
la I	permit. Departr Imports any Inju		21. Signature of Funeral Service Licen	see real CES	P	2	HÖTTÖW 501 Sn	Address of Fur ow Hil	neral 1 Rd.	Home Pr , Salis	ofess bury,	sional A , MD 218	ssociation
Ц			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	the death	. Do not ent	er the mode	of dying, suc	ch as cardiac	or respiratory	arrest,		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Sep	tic.	Shoc	K					Onset and Death DOYS
	/Medical Examiner			Due to (or as	a consequ	ience of):	1.60	20010		litis			1. lack-
	· with	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequ	ience of):	DITT	1416	· w	////3			WEERS
	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events	c									
Š	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al Ex	resulting in death, East	Due to (or as	a consequ	ience ot):							
	fficate y phys	edical		d									
5	w requires that the death certi been signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	pf pregna		∃Ectopic pre∉	inancv			4	23d. Date of deli	*
י נ	e deal the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (spec					Month	Day Year
-	that the		Part II. Other significant conditions o	ontributing to death b	ut not resu	Ilting in the u	nderlying cau	se given in F	Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
2	quires n sign uld be	d by								1 🗆	Yes 2	No 3□ Pro	obably 4 □Unknow
	law re as bee 2 sho	plete								24a. Was		24b. Were au	topsy findings availabl ompletion of cause of
	The rate has page	Completed								peri 1□ Yes	ormed2	death? 1 ☐ Yes	2 No
311.4	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Others		th (Check only			
5	Physer this eral dir	To:	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry	28b. Time o	nt 3□ DOA f 280	4[. Injury at Work?	Nursing H	ome 5 ☐ Res 28d. Describe		6 □Other (Spectry occurred	cify)
5	Attending Physician: The lavardeath. rector: After this certificate has by the funeral director, page 2	atior	1 Natural 5 □ Pending 2 □ Accident investigation		y Year)	Injury	М	Work? 1 ☐ Yes	2□No				
	al or Atter after der I Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inj building, et			eet, factory,	office		28f. Location City or To	Street an wn, State	d Number or Ru)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, f	Medical C	29a. Certifier Certifying Ph	y sician : To the best hiner: On the basis o and manner st	of examinat	wledge, deat tion and/or in	h occurred at vestigation, i	the time, da	ate and place	, and due to the rred at the time	cause(s)	and manner as d place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of contifier					icense num				te signed (Month	
	100		> 540	1	M	9		D000	29/	0	Feh	28	2007
1	00		30. Name and address of person who of the state of the st	completed cause of d	leath (Item	23a) (Type,	Print)			-, -		/	0 0/-
7	_	ate	31. Date filed (Month, Day, Year)	CTCZ N 32. Registr	ar's Signal	115 S	South	DiVI	5100.	57.	Wist	bury M	0 21804

Registrar

Glown H.

MAR 0 1 2007

IN

DHMH 17 Rev 1/2001

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 1209 Registrar's Signature

			1 = For State Registrar	State of Marylan	d / Depa	artment of F	lealth and	Mental Hy	giene 07	08409
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last COS GCT A. A. Facility Name (If not institution, give	MCKINI	JEY	4b. City, Town, o	r Location of Dea	2. Date of De Month MARU-	Day 12 Year 2007 4c. County of Deat	h
	Funeral Director		5. Social Security Number 226-48-7091 Cusual Residence of Decedent	x 7. Age (In yrs. M	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		y, Year) Co	nplace (State or Foreign untry) essee
	h the Maryland rr 28a-f show r notified at	irector	10a. State 10b. County MD Cecil 10e. Street and Number		y, Town or Lo				10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☑ No untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show appring the profiled at approximation of the control of the cont	by Funeral Director	965 Dr. Jack Road 11. Marital Status 1 Never Married 28 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: Vietr		21918 Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2☑ No		Specify Yes or No rto Rican, etc.)		
21215-0036	d within 72 hour giene. In then "natural Ibe Mades! Es	Completed t	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	during most of wi	orking	16b. Kind of Business/ U.S. Army	
Maryland	should be file and Mental Hy a marked othe rumatic event,	To Be C	17. Father's Name (First, Middle, Last) James D. McKinney 19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street	Mary E	yrd Rural Route Numb	, Maiden Sumame) er, City or Town, State, Z	Tip Code)
Baltimore, M	Pages 1 and 2 ient of Health int: If item 27 is iry or other tra		Mary L. McKinney 20a. Method of Disposition 1	Removal from State	Place of Dispo	Dr Jack I osition (Name of matory or other place cris & Co	ce)	Conowing Date 9/07	O, MD 2191 20c. Location - City or West Chest	Town, State
Balti	permit. Departmit. Imports any inju		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	yllngles		2. Name and Addre Tarring-(Aberdeen ter the mode of dyin				Approximate Interval Between
760, 75	The burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. END-5 FA Due to (or as a conseq b. Due to (or as a conseq	uence of): HA uence of): CC		SIPLICTIV	- Juin		Onset and Death
.O. Box 68	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregns 1□Live birth 2□Feta 4□Pregnant at time of d	I death 3	Ectopic pregnancy	,		23d. Date of deli Month	ivery Day Year
cords, P.	v requir	by	Part II. Other significant conditions co	intributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.			the cause of death? obably 4 □Unknown topsy findings available
		Be Completed	25. Was case referred to medical examiner?				26. Place of De	auto	psy prior to death? 2 No 1 ☐ Yes	completion of cause of
ot	iing Phys After this funeral dir	2	1 Yes No 27. Manner of Death Natural 5 Pending 2 Accident investigation	Hospital: Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	f 28c. Injury Wor	y at	-	dence 6 Other (Spec how injury occurred	cify)
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Il Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification: To the best of my known	y) 		ne, date and plac	City or To	Street and Number or Ruwn, State)	
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examination) 29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death occ	curred at the time,	date and place, and due 29d. Date signed (Monti	to the cause(s)
)	, \		30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type.		9406	70	MARCH, 10	th 2007
4.	Sta Registr	1.00	MOPIQUE FRAM- 31. Date filed (Month, Day, Year) MAP 1 6 2007	32. Registrar's Signa	CM		HOSPITA	1 106 1	sow st. E	MON, M.O.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
James C. Mason 2. Date of Death 3. Time of Death Day 200 7 ear March 1, **Physician** 2158 /Medical 4b. City, Town, or Location of Death Cheverly 4c. County of Death P. G. a Facility Name (If not institution, give street and number) Prince George's Hospital Center Examiner 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month. Days, Year) | April 1 24, 26 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 577-40-1180 1**□**M 2□F Director Maryland Usual Residence of Decedent 10b. County P.G. 10c. City. Town or Location 10d. Inside City Limits 10a. State Md 27 Is marked other than "natural", or itama 23a or 28a-1 show traumatic event, it is Madical Examinational Languistics at Mount Rainier 1 Yes 2 No Director 10e. Street and Number 2703 Webster St. Apt. # 2 10f. Zip Code 10g. Citizen of What Country? 20712 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1t Yes, Give 8 2 2 4 4 6 Year or Date? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Railroad Porter Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental I James C. Mason Rose B. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2703 Webster St. #2 Mount Rainier Md.20712 19a. Informant's Name/Relationship (Type, Pnnt) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is rr sny Injury or other traum once. Kimberly Griffin-Daughter 20b. Place of Disposition (Name of Chelical Centerly, crematory or other place)
Chelicanham
Veterans Cemetery 20c. Location - City or Town, State Cheltenham, Md. 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wash. D.C. 20001 Robinson Funeral Home 1313 6th St.NW 21. Signature of Funeral Service License 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Llehsella **Physician** disease or condition resulting in death) pueamonin /Medical Due to (or as a consequence of): Examiner mult 11/0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physician Physician/Medical the the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diseare reua 1 Yes 2 No 3 Probably 4 Unknown Completed Melhtu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Preg moria 1 Tes 2 -No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DUG 43662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Da. Cheverly, Md PG Boyce Hospita. MULAM 31. Date filed (Menth, Day, Year) 32. Registrar's Signature, State MAR 0 5 2007 Registrar

			1 - For State Registrar	State of Mary		artmen <i>rtificat</i>			nd Me		giene Reg. No.	007	08411
	Physici /Medi Examin	cal	1. Decedent's Name (First, Middle, Las. Florence 4a. Facility Name (If not institution, give Chester River Hosp	naxted	-	4b. City,	Town, or	Location of	r	2. Date of Dea Month March	Day 4c. Co	2007 ounty of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. Se		yrs. last birthday, 71 Yrs.	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Birtl	1	9. Birth	place (State or Foreign intry) CA
	the Maryland 28e-f ehow	Director	10a. State 10b. County MD QUEEN A		CHEST		C-4-				10- Cisir-		10d. Inside City Limits XXYes 2 □ No
	172 hours after death with the Maryland "natural", or Items 23a or 28e-1 show selfcal Expruirat Prust be notified at	Funeral Dir	202 ELLICOTT DRI	12. Was Decedent Ever Armed Forces?	in U.S. 13.	2	1619	spanic Orig n, Mexican,	in? (Spec	ify Yes or No- ican, etc.)	USA	n of What Cou	can Indian,
21215-0036	72 hours afte 'natural', or l	Š	1 Never Married 2 Married 3 Widowed 4 XDivorced 15. Decedent's Edi (Specify only highest grac	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: ucation fer completed)	16a. Dece	1 Tes	al Occupa	uring most	of workin	g I		pecify: WH	IITE ndustry
nd 2121		Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.	RETAR	se retired,	18. Mother	's Name	(First, Middle,	Maiden Su		
Maryland	12 should h and Men 7 le marke treumatic	Tol	DAVID MAXTED 19a. Informant's Name/Relationship (7) SEVAL J. FITZPATR			-		nd Number	or Rural	Route Numbe	r, City or T	NTGOMER Town, State, Zi MD 21	o Code)
Baltimore,	permit. Pages 1 and Depertment of Health Important: If Item 27 any injury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	b. Place of Dispo cemetery, cre CHESAPEA	osition (Nar matory or c KE CR	ne of ther place EMAT	ion 0	3/08	te	20c. Loca	tion - City or T	own, State
Bal	Depermine Depermine Important irruportant		23a. Part1. Enter the disease, or compshock, or heart failure. List only of	stylein lications that caused the		ELLOW 30 SP	S. H EÈ R		BEIN CHES			FUNERA 21620	Approximate Interval Between
8760,	death certificate be executed A settlending physicien and a for use as the burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. END-STAC Due to (or as a cor b. Due to (or as a cor c. Due to (or as a cor d.	sequence of):	DNIC	OB	STRU	CTIVE	E PUU		VCY GEASE	Onset and Death (6 MM th 5
P.O. Box 68	death certifi e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of print 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal déath 3	□Ectopic pi □ Other (sp					230	d. Date of deliv	ery Day Year
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tal Reco	in: The faw r ificete hes be or, page 2 sh	Completed	25. Was case referred to medical					00 51		·	sy med? 200 No	24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificete he completely filled in by the funeral director, page	ition: To Be	examiner?	Hospital: Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time o		8c. Injury Work	C 4 🗆 Nur	sing Hom	(Check only or e 5 ☐ Resid 3d. Describe h	ence 6	□Other (Speci	(y)
Divis	To the Hospital or Attend within 24 hours after death To the Funerel Director: / completely filled in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	pecify)				28	City or Tow	n, State)		al Route Number,
	To the Hospital or within 24 hours afte To the Funerel Directional Completely filled in the Funerel Direction of the Fune	Medical	29a. Certifier (Check only one) 2 Medical Examone) 29b. Signature and title of certifier	sician: To the best of my iner: On the basis of exar and manner stated.	knowledge, deat mination and/or in	vestigation	at the tim , in my op	inion, death	place, ar occurred	at the time, o	late and pl	nd manner as s ace, and due t signed (Month,	o the cause(s)
	2		30. Name and address of person who c	Months of death	(Item 23a) (Type,		1	415	87		31	7/2	.007
	Sta Registr		HELEN WBLE 31. Date filed (Month, Day, Year) MAR	MD (27) 32. Registrar's 2007				z£					

			For State	State of Mar	-	epartment o Certificate d				_	200	-7	001.17
	W. =		Registrar 1. Decedent's Name (First, Middle, La.	st)		oorimoato c	n Douti		. Date of De				3. Time of Death
	Physicia /Medic		Roy Spencer 1	McOueen				न	Month ebrua:	ry 2	-	07	11:51A M
,	Examin		4a. Facility Name (If not institution, giv			4b. City, Tow	n, or Location				County of D		
	Funeral Director		Southern Mary 5. Social Security Number 6. S 244-34-0911		In yrs. last birtl	hday) If Under 1 Ye Months Da		er 24 Hrs. 8. Min.	Date of Bir (Month, Date 2)	ay, Year)	9.	Birthplac Country	,
			Usual Residence of Decedent						eb. 20	0, 1	928 I N		Carolina
	arylar show d at	-	10a. State 10b. County	1	0c. City, Town	or Location						10d	Inside City Limits 1 ☑ Yes 2 ☐ No
	he Mi	Director	Maryland Prince 10e. Street and Number	George's		10f. Zip Coo	Suit1	and		10a Cit	izen of What	Causta	ZX
	with a or a			Design #D		Toi. Zip Coc		716		rog. Cit			_
	ms 23	Funeral	3527 Terrace 11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent		0746 Origin? (Specif	y Yes or No)-	14. Race - A	merican	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ▼No if Yes, Give Year or Dates:		1 ☐ Yes 2 ☐			can, etc.)		Black, W	Afr	ican erican
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2	shoul nd Me mark	2	19a. Informant's Name/Relationship (19b.	Mailing Address (Str	eet and Num	nber or Rural F					ode)
Ě	and 2 alth a 27 is er tra		Rolanda E. Thor	nas/Daughter	r	2146 W.	Pataps	co Ave	., Bai	ltimo	ore, M	D 2	21230
ָרָ פֿ	of He of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of	Disposition (Name or , crematory or other	1	Date			ocation - City		n, State
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2	permit. Depart Import any inj once.		21. Signature of Funeral Service Licer	# 4-		22. Name and Ad		silitar		Fune	eral H	ome	
			mycell .	Versal (a death Dea			ng Rd.			h., DC		
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	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c		t/·						4	
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O. DO.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tir 9□Unknown	☐ Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify					23d. Date of Month	delivery Da	
,	s that ned by e deta	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause	given in Par	t i.	23e. Did 1	tobacco u	use contribut	e to the	cause of death?
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	ding F	ion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	rear) 28b. Ti		njuryat Work? 1 ∐ Yes 2[d. Describe	how injui	ry occurred		
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2	al or / s after Il Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)				City or To	wn, State	e)		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one)	nysician: To the best of niner: On the basis of eand manner state	xamination and	death occurred at the	e time, date ny opinion, d	and place, and leath occurred	d due to the I at the time	cause(s , date an) and manne d place, and	r as stat due to th	ed. he cause(s)
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			1 - For State Registrer	State of	Marylan	-	artment rtificate			and M	lental Hyg	jiene ()	07	08413
ı	Physici	an	1. Decedent's Name (First, Middle Martha	, Last) Hele	en	Pair	ne	Mil	ller		2, Date of Dea Month March	Day	Year	3. Time of Death 1:25 P ^M
	/Medic Examin		4a. Facility Name (If not institution Beverly Living			ıd		Cumb	Location o	nd			nty of Death	
	Funeral Director		5. Social Security Number 415–12–1778	6. Sex 7 1 ☐ M 2 🂢 F	. Age (In yrs. 86	last birthday) Yrs.	If Under Months	1 Year_ Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 07/06/1	Year) 920	Cou	place (State or Foreign Intry) nigan
	e Maryland 8a-1 show	ector		egany	10c. Cit	y, Town or Lo Cu	mberl			-		0.11	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the 23a or 2 ust be n.	Funeral Director	10e. Street and Number 40 Gleas	son Street			10f. Zip		215			J	JSA	
920	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be confilled at	b	11. Marital Status 1 □ Never Married 2 □ Marria 3 ☒ Widowed 4 □ Divorced	If Yes, Give	es? P∏No		Was Deced If Yes, spec 1 ☐ Yes — 2	ify Cuba	spanic Ori n, Mexicar Specify:	n, Puerto	ecify Yes or No- Rican, etc.)	E	Race - Ameri Black, White, acify:	
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ore, Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Itam 27 Is marked any injury or other traumatic e ange.		19a. Informant's Name/Relations Barbara Friding 20a. Method of Disposition 1∑ Burial 2 □ Cremation	ger / Niece	20b. F	11 (Place of Dispo	Columb osition (Naminatory or o	oia i	Stree	et, C		nd, MI		02
Baltimore,	permit. Pag Department Important: I any injury o		4 Donation 5 Other (S	pecify)	Sur	22	2. Name an	d Addres	s of Facili	ty Ad		ily Fu		MD Home, P.A. 21502
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	nrs		30. Name and address of person Sunil K. Gu	pta, M.D.,	625	Kent A		, Cu	mber]	land,	Maryla	nd 2	1502	
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			1. Decedent's Name (First, Middle, L	.ast)						2. Date of De		ay Year	3. Time of Death						
	Physici /Medi		Mabel	E.			Mi.	ller		March		2007	2:45 A M						
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15	Funeral Director	1 2	182-14-1434	Sex 7. Ag 1☐ M 2☐ F	e (In yrs. 88	last birthday) Yrs.	If Und Month		If Under 24 Hr: Hours Min		y, Year	9. Bir	nthplace (State or Foreign ountry)						
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City Limits						
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic svant, the Modical Examiner must be notified at any office.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	If Yes, Give				edent of Hi becify Cuba 2 1 No	spanic Origin? (: n, Mexican, Pue Specify:	Specify Yes or No no Rican, etc.)	•	14. Race - Am Black, Whi Specify:							
8	hour	d D		Year or Dates:															
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22	lled lygie ther nt, th		17. Father's Name (First, Middle, Las	:(1)		нс	mema	aker	10 Mother's No	me (First, Middle,	A de iele	Home							
Maryland	ould be i Mental I arked o	To Be	Elmer	0.		Turne	r		Minnie		S.	n Surname)	Mowry						
<u>la</u>	2 sh and is m		19a. Informant's Name/Relationship			19b. Mailir	ng Addre	ss (Street a	nd Number or R	lural Route Numb	er, City	or Town, State,	Zip Code)						
<u>~</u>	and lealth m 27 her to	7,	Robert K. Mille	r / son	_				h Road,	Bedford									
0	Jes 1 If its or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State	206. P	lace of Dispo emetery, cren	sition (N n <i>atory</i> o	ame of other place		Date	20c. l	_ocation - City or	Town, State						
Ë	Pag ment ant: ury	- 4	4 ☐ Donation 81☐ Other (Spec		Dry	Ridge		,		08/2007		ıns Choi							
Baltimore,	Departition of the point of the		21. Signature of Funeral Service Lice	Calle						dams Fan C, Cumber			1 Home, P.A. 21502						
$\int_{\mathbb{R}^{2}}^{t} dt$	Physician Medical Physician and Medical Examiner	Ilcal Examiner	ca	cal	cal	cal	Cal	ca	23a. Part1. Enter the disease, or co shock, or heart failure. List online disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. REW	a consequence consequence	FAIL uence of): EWS10 Auence of).	VR		, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death ONE WEEK
P.O. Box 6	res that the death certifics igned by the ettending pt be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic Other (pregnancy specify)				23d. Date of de Month	livery Day Year						
۵.	that the bod by detail	윤	Part II. Other significant conditions	contributing to death be	ut not resu	ulting in the ur	nderlying	cause dive	n in Part I.	23e, Did to	obacco	use contribute to	the cause of death?						
ords	w requires been sign should be	Q	PNEVMONIA							10	res 2	2 No 3 □ P	robably 4 Unknown						
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ā	an: rtifica tor, p	Bec	25. Was case referred to medical	1					26. Place of De	1 ☐ Yes ath <i>Check only</i> o		1 1 1 1 1 1 1	2 140						
>	ysic is ce direc	10 E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1 Inpatie	nt 2 🗆	ER/Outpatien	t 3 🗆 E	OA Cthe				6 ∏Other /Spe	icifu)						
Division of Vital	ing Afte		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury			28d. Describe I	be how injury occurred									
Divis	0 = 0 =	Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place of Inju				28f. Location (Street and Number or Rural Route Number, City or Town, State)			ural Route Number,								
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best of the basis of and manner sta	examinat	wledge, death ion and/or inv	occurre	d at the timen, in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s date an	s) and manner as od place, and due	s stated. e to the cause(s)						
	To the within 2.	Me	29b. Signature and title of certifier				2	9c. License	number		29d. Da	ate signed (Mont	h, Day, Year)						
	(3)		· COO	Com				D3	3417		Ма	rch 6, 2	2007						
	Roh		30. Name and address of person who James R. Moen	, M.D., 10	eath (Item 068 N	^{23a)} (Type, I ationa	Print)	ghway	, LaVal	e, Maryl	and	21502							
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0	32. Registra		ure	Soa	B. D											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 507 AM Year **Physician** Moral 2000 Charles Junior MCLUCAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hagerstown
If Under 1 Year If Under 24 Hrs. 205 Rock Willow Avenue Washington 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1X1M 2□ F Yrs. Director 78 July 28 1928 219-20-4533 Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ∑Yes 2 ☐ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Rock Willow Avenue 21740 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mentel Hygiene. int: If Itam 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Foreman Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. McLucas ပ Kathryn D. Kaylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if itsm 27 is sny injury or other traisons. Joanne McLucas - Wife 205 Rock Willow Avenue, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Rose Hill Cemetery 3/9/07 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 5 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chacer Colon Year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if the last in the last cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physicien and s the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

The law requires that the death certificate be executed Box 68760, use as attending for use as signed by the a o ے of Vital Records, hes funeral director this After Division i after death.

i Director: After din by the fur filled in by l or A within 24 hours a To the Funeral C completely filled i To the Hospital

death

within 72 hours after

Baltimore, Maryland 21215-0036

5H-9

State Registrar 31. Date filed (Month, Day, Year) MAR 07

29b. Signature and title of certifier



Melan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

29c. License number

041667

Chapes

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 9.58 PM **Physician** March 3 2001 Betty Margaret MURPHY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕅 F 87 Director May 1 1919 Ohio 293-14-6912 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mentel Hygiene.

n 27 is marked other than "natural", or items 23a or 28a-f show her fram with the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number Funeral 20009 Rosebank Way USA 14. Race - American Indian, 21742 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White þ 3 ☐ Widowed 4 🏋 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Her own home</u> Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Roy Gentry Pearce Marjorie McKinney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. Ken Murphy 11827 Partridge Trail, Hagerstown, Md. 21740
e of Disposition (Name of Date 20c. Location - City or Town, State - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 3/6/07 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or o' mplicat ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Altresolastu Condio vosculor **Physician** MMS. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): 14-cow. Sequentially list socialities, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been signated Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autonsy certificate ha 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ this (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred within 24 hours after uccur.

To the Funeral Director: After To the Funeral Director. Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

3H-20 State Registrar 29b. Signature and title of certifier Monney

31. Date filed (Month, Day, Year) MAR 07 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29c. License number

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that the death certificate be executed P.O. Records, Division or Vital this After Hospital or Attending within 24 hours after de To the Funeral Directo completely filled in by the

week 23d. Date of delivery Month Year Day 9□Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2VINo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D 44996

3. Time of Death

10d. Inside City Limits 1 X Yes 2 □ No

29d. Date signed (Month, Day, Year)

Boonsboro MO 21713

SH-1 State Registrar

To the I

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

far Malik

29b. Signature and title of certification

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26311 Cappans Rd

State Registrar

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PENNSYLVANIA

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AVENUE

ITAGETES TOWN

Mar	of Death 3. Time of Death
LENORA ODEN Feb.	4c. County of Death
Funeral 5. Social Security Number 6. Sex 1 Months Days Hours Min. (Months Days Hours Min. SEPT)	9. Birthplace (State or Foreign Country) 17, 1916 PENNSYLVANIA
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 300 ARTIC AVE. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes)	10d. Inside City Limits 12 Yes 2 No 10g. Citizen of What Country?
Armed roces: 1 Navar Married 2 Married 1 Types 2 M No	s or No- ttc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16b. Kind of Business/Industry OWN HOME
TO EIFE at 17, Father's Name (First, Middle, Last)	
20a. Method of Disposition 1 \(\times \) 1 \(\times \) 20a. Method of Disposition 1 \(\times \) 20a. Method of Disposition 1 \(\times \) 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 \(\times \) 1 \(\times \) 20a. Method of Disposition 1 \(\times \) 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 \(\times \) 1 \(\times \) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 \(\times \) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition 20c. Method of Disp	YEADON, PA
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respire shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Batween Onset and Death
IF FEMALE: 23b. Was decedent pregnant 1 1 1 1 1 1 1 1 1	23d. Date of delivery Month Day Year
The table of the table of the table of	e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ ₩6 3 ☐ Probably 4 ☐ Unknown
248 Light Street Control of the con	a. Was an autopsy performed? Yes 2 2 10 0 1 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 10 No
25. Was case referred to medical examiner? 1 Yes 2 Mo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. De	k only one) ☐ Residence 6 ☐ Other (Specify)
Comparison Com	scribe how injury occurred
27. Manner of Death 1	ation (Street and Number or Rural Route Number, r or Town, State)
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number	e time, date and place, and due to the cause(s)
0 21381	29d. Date signed (Month, Dey, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 2180 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	4

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

death with the Maryland

72 hours after

Maryland 21215-0036

Baltimore,

3093

n 24 hours a within 2 To the

State Registrar 29a, Certifier

(Check only

29b. Signature and title of certific

DAVIS MO

Year)

Medical

DHMH 17 Rev 1/2001

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and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

054127

29d. Date signed (Month, Day, Year)

21804

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			State of Manyland / Dor	·	
			1_ State	partment of Health and Mental Hy ertificate of Death	2007 00421
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of D	eath 3. Time of Death
	Physici		Joyce Evelyn Peggins	Month Follows	Day Year
100	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ry 27, 2007 11:50 " 4c. County of Death
			Washington Adventist Hospital	Takoma Park	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min. (Month, D	irth 9. Birthplace (State or Foreign Country)
2	Director		Usual Residence of Decedent	09/04/	1931 California
	yland now		10a. State 10b. County 10c. City, Town or L	Location	10d. Inside City Limits
	Man B-f et	tor	Maryland Prince George's Laurel		¹ ☐ Yes 2 🛣 No
	e 23a or 28e-f e how	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath w		15919 Jerald Road	20707	United States
	er de Item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	II', or	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 XNo Specify:	Specify: White
Maryland 21215-0036	d within 72 hours after death with the Maryland jiene. Trie Medical Expression 23s or 28e-f ehow tre Medical Expression to the notified at	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Industry
215	thin 7	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	
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and	d in a	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
2	should and Men marke umatic	욘	Walter Edgar Pavne 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Evangeline Smit	
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ē,	of Health of Health filtem 27 i		20a. Method of Disposition 20b. Place of Disposition	Snowden Loop Court, Laul Date Pharactery or other place)	20c. Location - City or Town, State
Ë			1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) □ Twmaculat	Mary 03/03/2007	Lexington Park, MD
Baltimore,	permit. Pag Depertment Important: I eny injury o			22. Name and Address of Facility Brinsfie	
<u> </u>	#Q E 2 9			2955 Hollywood Road, Leon	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		arrest, Approximate Interval Between Onset and Death
10	Physician		Immediate Cause (Final disease or condition resulting in death)	SHOCK.	Short and Dodan
-	/Medical Examiner		Due to (or as a consequence of):	ENDOCARDITIC.	
1.00		er	Sequentially list conditions		
	te be executed ysicien and ie burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	FIBRILLATION'	
ó	en an rial-tr		resulting in death) Last Due to (or as a consequence of):	SCHEON SHIP	
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Ilcai	d 141501/18	DCYTOPENIA.	
89 x	leath certificate attending phy: I for use as the	Physician/Medi	IF FEMALE:		
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Œ.		Completed	DVARSETET TYPE I	peri 1 ☐ Yes	prior to completion of cause of death? 2 No 1 Yes 2 No
/ita	sicien: Th certificete rector, pag	Be (25. Was case referred to medicat examiner?	26. Place of Death (Check only	one)
Division of Vital Records,	shys this al dir	7	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		
uc	ding After fune	ion	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) 2 Accident investigation		how injury occurred
İSİ	or Attending ifter death. Director: After in by the fune	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		(Street and Number or Rural Route Number,
ē	al or safter	erti	4 Homicide determined building, etc. (Specify)	City or To	own, State)
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	caic	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
	the H iin 24 the Fi	ledical	one) and manner stated.		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
7			> 3 A OUMMINI	N-3-170-01	7/2/004
X	0		30. Name and address of person who completed cause of death (Item 23a) (Type SHAHA) SHAMIM. MD LNADAL	D-59284 NGTON ADVENTIST 1659	TAKOMA PARK
5246	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature		HD-20912
	Registr		MAR 0 2 2007 Steer &	no le	

			1- State of Maryland	-	artment of Health and rtificate of Death		6.001	08422
			Negistrar 1. Decedent's Name (First, Middle, Last)		rimeate of Beatif	2. Date of Dea		3. Time of Death
	Physicia /Medic		Folith M Price			Fe har	Day Year	7 1735 PM
4	Examin		Aa. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	th	c. County of Dea	
			Chester Kiver Hospital Ce	nter	Chesterta	<u>un</u>	Kent	
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. In 222-07-3487 1□ M 2☒ F 85		If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Bii	thplace (State or Foreign ountry) DE
	D		Usual Residence of Decedent					
	anylan show	<u>_</u>	· · · · · · · · · · · · · · · · · · ·	y, Town or Lo LLINGT				10d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	1
	3a or		213 GROFF ROAD		21651		USA	outiny ?
	death	Funerail	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Am	
36	s after , or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 Yes 2 No Specify:	to riioan, etc.)		HITE
Ş	within 72 hours after death with the Maryland ene. Than "natural", or items 23s or 28s-f show "a Medical Examiner must be invitted at	ed b	3 XWidowed 4 □Divorced Year or Dates:	16a Dece	dent's Usuat Occupation		16b. Kind of Business	
215	hin 72 In "ne Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0.12) Coltege (1.4or 5+)	(Give	kind of work done during most of wo DO NOT use retired)		TOD. Raid of Educations	unidustry
2	filed with Hygiene other the	Completed	11	ASS	EMBLY LINE WORKE	R	FOOD SERV	ICES
Maryland 21215-0036	be fill tal Hy od oth	Be	17. Father's Name (First, Middle, Last) JAMES CALVIN BICKLING			me (First, Middle, LOCKWOOD	Maiden Sumame)	
ڇ	should and Men marke umatic	၉	19a. Informant's Name/Relationship (Type, Print)	19h Mailii	ng Address (Street and Number or R		r City or Town State	Zip Code)
<u>≅</u>	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelin and Mental Hygiene. If the m 27 is marked other than 'natural', or items 23a or 28a-f show it it is marked other than 'natural', or items 27 is marked other than 'natural'.		SETH A. PRICE, III/SON		O JEBB ROAD, CAM		•	
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Important: If Item 27 is eny injury or other tra		1 TRurial 2 Cramation 3 Demoval from State C6	emetery, crer	osition (Name of matory or other place)	Date	20c. Location - City or	
Ĕ	Pag tment tant: i		4 ☐Donation 5 ☐ Other (Specify) MII		ON ASBURY CEM. O			
Ba	Depar Depar Impor eny in		21. Signature of Funeral Service Licensee	F 22	2. Name and Address of Facility ELLOWS HELFENBE	IN AND NE	WNAM FUNER	AL HOME, PA
			23a. Part1. Enter the disease, or complications that caused the death	1 1	30 SPEER RUAD, CI	HESTERIOV	VIN, MID 2102	Approximate
	Physician		shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition	1 1	Failure			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence)	ience of):	•			
	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
	uted Insit	Examiner						
ó	execuence of the second of the		resulting in death) Last Due to (or as a consequ	ience of):				
8760,	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai	d					
9 ×	h certific anding p use as	/Mec	IF FEMALE: 23c. If yes, outcome of pregnar	ncv				
Вох	death certif attanding for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	Day Year
о. О	by the tacher	hys	9 Unknown					
s,	res that the de signed by the a be detached t	by	Part II. Other significant conditions contributing to death but not resu	ilting in the u	nderlying cause given in Part I.)	bacco use contribute t	
Ö	w require been si	eted	C. ST.VE C)	1 1)1(01 ~	1 1	es 2□No 3□P	robably 4 □Unknown
Re	he law has l ge 2 s	Completed				24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
		Be Co	25. Was case referred to medical		26 Place of De	1 ☐ Yes ath (Check only or		s 2□ No
<u>=</u>	nysici nis cer direci	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	ER/Outpatien	Other		ence 6 □Other (Spe	ocify)
Division of	*Attending Physician: The sr death. ** **********************************		27. Mann of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	Work?	28d. Describe h	ow injury occurred	
Sico	oter: /	cati	2 Accident investigation 3 Suicide 6 Could not be 389 Place of Injury. At hor	mo form str	M 1 Yes 2 No	29f Location /S	treet and Number or R	um I Davida Numbar
<u>≥</u>	al or Attend efter death Director: d in by the	Certification:	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify,))	eet, ractory, office	City or Tow		urar Houte Number,
	To the Hospital or Attending Physician: within 24 hours elter death. To the Funerel Director: After this certifica completely filled in by the funeral director.		29a. Certifier (Clear only 201 Certifying Physician: To the best of my know 201 Medical Examiner: On the basis of examinati	wledge, deati	h occurred at the time, date and place	e, and due to the c	ause(s) and manner a	s stated.
	the H the F the F	Medicai	and manner stated.		00-1		201 8-1-1-1-1-1	- C- V 1
	₽¥° S		29b. Signature and title of certifier		29c. License number D 36 () 5 ×		29d. Date signed (Mon	in, Day, Tear)
,	5		30. Name and address of person who completed cause of death (Item	23a) (Tvpa.	Print)		0 - d1	2 1125
n.	1		30. Name and address of person who completed cause of death (Item	30	Spean Kd CH	estend	m MD	21620
	Sta Registr	te	31. Date filed (Month, Day, Year) 32. Registry's Signate MAR 0 1 2007	ure	bot			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Day Brent Arthur Rule March 2007 7:40 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27312 Harpers Ct. Mechanicsville St. Mary's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 13K M 2 □ F 456-92-0729 Director 48 April 16, 1958 Texas Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD St. Mary's Mechanicsville 1 ☐ Yes 21 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 27312 Harpers Ct. 20659 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Analyst Engineer Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Arthur Rule Phyllis Phyllis Mae Shorb ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Rule (Wife) 27312 Harpers Ct., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Cre 03/09/2007 | Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Kyle S. Simons 22955 Hollywood Rd., Leonardtown, Maryland 20650 M01206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** gmonths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ₹ 0 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 2 3 No 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one) examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 1 Yes 2 No 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; / 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a, Certifier LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 20680 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 Point Lookout Road Leonardtown, Maryland 20650 Gurdeep Chhabra, MD. 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar MAR () 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Garnett Edwards Rawlings 11:30 A^M March 2, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Village Nursing Home Frostburg 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Months 1 X M 2 □ F Days Hours 90 214-05-6825 08/30/1916 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Allegany 1 X Yes 2 □ No Director Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 515 Greene Street 21502 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Military Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Rawlings Clara ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter J. Gordon / nephew 247 Kevington Place, Alameda, CA20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 03/07/2007 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. C 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Welks disease or condition resulting in death)

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events.

The law requires that the death certificate be executed

by Physician/Medical Examiner the burial-transit attending physician and for use as the burial-trar ate has been signed by the a page 2 should be detached to Completed After this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

To the

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown
Part II. Other significant con

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown
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_		
3 ☐Ectopic pregnancy		
5 ☐ Other (specify)	 	_

23d. Date of delivery Month Day Year

II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.
Congestive heart	Failure. Tschemic
Cardio my shatty.	Hypoalbuninem

Due to (or as a consequence of):

Due to or as a consequence of

Due to (or as a consequence of)

24a. Was an	24b.	Were autopsy fir	ndings availab
1 ☐ Yes	2□ No	3 ☐ Probably	4 Unknov
236. Did tobac	co use con	indute to the cat	ise of death?

25. Was case referred to medical examiner? 1 ☐ Yes 2 No
27. Manner of Death

l	1 Inpatient 2	E
	28a. Date of Injury (Month, Day Year)	
n		

3 🗆 [DOA	Other.	4 💢	Nursing	Н
	28c.	Injury at Work?			
M		1 🗌 Yes	2	□No	

Was an	24b. Were auto	opsy findings available			
autopsy	prior to completion of cause of				
performed?	death?	•			
Ýes 2. ΣX No	1 ☐ Yes	2 □ No			
anly one)					

1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time o Injury
28e. Place of injury - At he building, etc. (Special	ome, farm, str by)

nt	3 🗆 [OOA	Other: 4	Nursing H	ome	5 🗌 Residence	6 ☐Other (Specify)
of		28c.	Injury at Work? 1 ☐ Yes			Describe how inju	
reet, factory, office						Location (Street a	and Number or Rural

26. Place of Death (Check

1

	-				
Location City or T	(Street and own, State)	Number	or Rural	Route	Number,

21532

MD

29a. Certifier
(Check only
one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s
and manner stated.

Signature and title of ce	rtifier 7	
•	20	Jonath

D	1	4	4	6	4
7	1	tr	11	1	11

29d.	Da	te	sigr	ned	(Moi	nth,	Day,	Year)	
	0	N	3	6	5	/	2	007	7

ı	30. Name and	address	of persor	n who	completed	cause of	death	(Item 23a)	(Type	, Print)
1	 C	- 1-0-10	مدماہ	T	Condh		N/I T	`	li Q	T-0.10

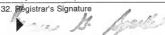
Sikander	L.	Sandhir.	M.D.,	48	Tarn	Terrace.	Frostburg

State Registrar

nH

Medical

31. Date filed (Month, Day, Year) 0 6 2007 MAR



R/Outpatient

		1 - For State Amend Item #2	State of Maryland, QACHD per DR		rtment of Heificate of L		ınd Mental H	ygiene Reg. No.	2007	08425			
Planei		1. Decedent's Name (First, Middle, Last)	-3/13/U/ = NG				2. Date of I Month	DeathMar	ch 4,200	73. Time of Death			
Physic /Med		HOWARD VINCENT ROSE	KOSKY, SR				MARCH	,	2007	7:00 A ^M			
Exam	iner	4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location o	f Death	4c.	County of Death				
		2706 SHERMAN DRIVE 5. Social Security Number 6. Sex	7. Age (In yrs. last		CHESTER If Under 1 Year	If Under 2	24 Hrs. 8. Date of E		UEEN ANNE	ace (State or Foreign			
Funera Directo			M 2□F 81		Months Days	Hours	Min. (Month, I	Day, Year)	925 CONN	try)			
		Usual Residence of Decedent					TWOTTHE		723 OOM	LOTICET			
ie, intering interior 2.12.15.0000 s. 1 and 2 should be filed within 72 hours after death with the Maryland I Heelih and Mental Hygiene. I the marked other than "natural; or items 23s or 28s-f show other traumatic event, the Medical Examination must be notified at		10a. State 10b. County	10c. City, T	own or Loca	ation				10	Od. Inside City Limits			
	Director	MARYLAND QUEEN ANN	IE'S CHEST	ER	T				1 ☐ Yes 2 🛣 No				
	Dir.	10e. Street and Number			10f. Zip Code				10g. Citizen of What Country?				
ier death w Itama 23a	Funeral	2706 SHERMAN DRIVE	2. Was Decedent Ever in U.S.	13. W	21619	spanic Orio	nin? (Specify Yes or I	No-	SA 14. Race - America	an Indian.			
fler d	Fun	1 Never Married 2 Married	Armed Forces? 1 XYes 2 ☐ No				gin? (Specify Yes or I , Puerto Rican, etc.)		Black, White, etc.				
72 hours aft	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1943–19	47	□Yes 2XINo	Specify:		Specify: WHITE					
72 ho	etec	15. Decedent's Educing (Specify only highest grade		(Give ki	nt's Usual Occupa	lurina most	of working	16b. Kir	nd of Business/Ind	lustry			
Men.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ilite. DO SALESM	O NOT use retired))	•	A TITTLE	MOTTE				
Hygie thert		12 17. Father's Name (First, Middle, Last)	0	DALEST		18. Mothe	r's Name (First, Midd		OMOTIVE Sumame)				
If year to Kital Should be filed within and Mental Hygiene. Marked other than imatic avent, tra M	Be C	VINCENT ROSKOSKY					ORLOSKI		<i></i>				
2 should and Men is marke	J.	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing			r or Rural Route Num	nber, City or	r Town, State, Zip	State, Zip Code)			
and 2 and 2 m 27 is no 27 is nor trau		MARIE VIEN ROSKOSKY	//WIFE	2706	SHERMAN	DRIVE	, CHESTER	, MARY	TLAND 216	519			
		20a. Method of Disposition	com	e of Disposi	tion (Name of story or other place	θ)	MARCH 8,	20c. Lo	cation - City or To	wn, State			
Pages nent of I int: If it		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State		LE CEMET	1	2007	STEV	VENSVILLE	, MARYLAND			
permit. Page Depertment of Important: If any injury or		21. Signature of Fune get Service License	1/	10	6 SHAMRO	CK RO	EIN AND NI AD, CHESTI	EWNAM ER, MA	FUNERAL	HOME, P.A.			
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	eti as that caused the death. I e suse on each line.	Do not enter	the mode of dying	g, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death			
Physician /Medica	_	Immediate Cause (Final disease or condition resulting in death)	freuma						5	days			
Examine			Due to (or as a consequen	ice of):						,			
	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	ce of):									
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequen	ce of):		-							
ate be executed hysician and the burial-transit	Ical	d.											
artifica ing pt	Med	IF FEMALE:						1					
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	ath 3 □E	Ectopic pregnancy Other (specify)			2	23d. Date of delive Month	ry Day Year			
ched the d	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	. 301	Ottler (specify)								
that thed by deta		Part II. Other significant conditions cont	ributing to death but not resulting	ng in the und	derlying cause give	en in Part I.	23e. Di	d tobacco u	se contribute to th	e cause of death?			
dures or sign	d by	hypertension					1	TYes 28	No 3 Prob	ably 4 □Unknown			
shot shot	Completed	71					24a. W		24b. Were autop	osy findings available			
The lay te has ege 2	E O							topsy orformed?	death?	npletion of cause of			
inn: Inflica Itor, p	0	25. Was case referred to medical		A-1116		26. Place	of Death Check on		10.00	20.10			
nysici nis ce direc	To B	examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient	3□ DOA Othe	er: 4 □ Nu	rsing Home 5 Re	esidence 6	6 □Other (Specify	<i>'</i>)			
ng Pl		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury Work		28d. Describ	e how injury	y occurred				
tendi leath. for: A	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□!							
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, office			n (Street and Town, State)	d Number or Rura.)	l Route Number,			
pital ours a naral filled		29a. Certifier 1 Certifying Physi	 ician: To the best of my knowle	dge death	occurred at the tim	ne date an	d place, and due to the	ha causa(s)	and manner as st	ated			
24 hu Fur	edical	(Check only 2 Medical Examinone)	er: On the basis of examination and manner stated.	and/or inve	stigation, in my op	oinion, deal	th occurred at the tim	e, date and	place, and due to	the cause(s)			
To th To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date	e signed (Month, I	Dey, Year)			
/		Jame Dan	- mg		1913	39		03	106/20	7			
1.													
(12/15)		30. Name and address of person who con	npleted cause of death (Item 23		rint)	<u></u>							
(12/2s)		JAMIE HARM m			rint)	STEVE	WIVILE	m	21666				
(PAS) S Regis	tate	30. Name and address of person who con TAmic HAMM m 31. Date filed (Mosth Day, Year) 2007	npleted cause of death (Item 23 IIS SALITS Registrar's Signature		rint)	Steve	MIVILE	m	21666				

DHMH 17 Rev 1/2001

Nicholas Stephe	n Sa		or Print in Blace e of Maryland												
		1- For State	e or Maryland /		tificate d		and Ment		g. No. 200	7 08420					
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,L	ast)					2. Date of Death		3. Time of Death					
Medical Exami	ner	Nicholas	Stephen		_	Sabath	_	March 7, 2	007	1903 hrs					
7		4a. Facility Name (if not institution, Washington Countty Ho				4b. City, Tow Hagerst	n, or Location of	Death	4c. County of Deat Washington	h					
Funeral			<u> </u>	e (In vrs. la	ast birthday)	If Under		24Hrs 8 Date of Birt	h(MM/DD/YYYY) 9. Bi	rtholace (State or					
Director			XXM 2 F	49	Yı	Months	Days Hours	Min.	Forei	gn					
	ŀ	Usual Residence of Decedent				15.		Nov. 3	0, 1957 Co	PA PA					
' any		10a. State 10b. County		10c. City,	Town or Loca	ation				10d. Inside City Limits					
land f shov	ō	MD Washin	gton	Hag	gersto	wn				1 Yes 2 X No					
Mary r 28a- ed at	Director	10e. Street and Number				10f. Zip Co	ode	10	g. Citizen of What Cou	intry?					
death with the Maryland or items 23a or 28a-f show must be notified at once.	무	21338 Leitersbu	rg Pike	Cuerie II	6 42 14	217		n? (Specify Yes or No-	U.S.A.	rican Indian, Black,					
eath w	Funeral	1 Never Married 2 Marr	ed Armed Forces?					Puerto Rican, etc.)	White, etc.	ican indian, black,					
ther d	by F.	3 Widowed 4 X Divorc	1 Yes 2	X No	1	Yes 2X	No specify:		Specify: Wh	ite					
natura (xami)		15. Decedent's Education (Specify					cupation (Give ki		16b. Kind of Business	Industry					
36 in 72 h nan "r	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)				55 (54)	II 11-1						
-000 1 within ther the	E	17. Father's Name (First, Middle, La	Cabi	net Mai		Name (First, Middle, M	Woodworki	ng							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Stanley Sabath	,					ret Elizab							
21 nould be id Mer is mar	2	19a. Informant's Name/Relationship							ber, City or Town, State	e, Zip Code)					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Stephanie a. Sab	ath/Daughte			8 Leit		Pike, Hage	rstown, MD 20c. Location - City of	21742					
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 X Burial 2 Cremation	3 Removal from Sta	ate (crematory or o	other place)									
tim t. Pag tment rtant:		4 Donation 5 Other Spec 21. Signature of Funeral Service Lic	sify:	Re		en Ceme	-		Hagerstown n Funeral (
Bal permi Depa Impo injur		21. Signature of Funeral Service Lin	E.						agerstown,	•					
Physician		23a. Part I. Enter the disease, or co		the death.				rdiac or respiratory arre		Approximate Interval					
/Medical Examiner		failure. List only one cause or Immediate Cause (Final disease	a. Multiple Injuries							Between Onset and Death					
LXaIIIIIei		or condition resulting in death)	Due to (or as a conse	equence o	f):										
	er	Sequentially list conditions, if any, leading to immediate	any, leading to immediate Due to (or as a consequence of):												
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C		r.										
ansit ansit		events resulting in death) Last	Due to (or as a conse	equence o	1).										
e executed cian and rial - transit	dical	UNPENDED	AMENDED												
Box 68760, e death certificate be the attending physicied for use as the burined buring buring and the burined for use as the burined for	cian/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of preg	_	40.5		-	23d. Date of deliver	•					
r 68 certif ending use as	cian	past 12 months?	1 Live birth 4 Pregnant at	time of de	oth	Fetal death Other (Specif)		pregnancy	Month	Day Year					
Box e death c the atten ed for us	hysi	1 Yes 2 No 9 Unkno	9 Unknown		٠ الــــا ١	Other (opcom)	,								
Division of Vital Records, P.O. Box 68760, with 124 hours after death certificate be within 24 hours after death. To the Fundant or After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	by PI	Part II. Other significant condition	ns contributing to deat	h but not r	esulting in the	e underlying ca	ause given in Par	t I. 23e. Did to	bacco use contribute to	the cause of death?					
IS, F quires en sign								24a. Was a		utopsy findings available					
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should t	Completed							autop	sy prior to	completion of cause of					
Rec The I	Con							1 🗸 Yes		es 2 No					
ital iician: s certi	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2	ER/Outpatie		Place of Death (Residence 6 Other	er:					
n of Vi ding Physi After this	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry	28b. Time o		c. Injury at Work?	28d. Describe h	now injury occurred						
on c ending ath. or: At	tion	1 Natural 5 Pendir		'ear)	1824 hrs		1 Yes 2 🗸	No Driver auto	auto collision						
Division tall or Attending after death.	ifica	2 ✓ Accident Investi 3 Suicide 6 Could	28e Place of In	ijury - At h	ome, farm, st	reet, factory, c	ffice building, etc	28f. Location (S or Town, S		tural Route Number, City					
Divisior Hospital or Attend 24 hours after death Funeral Director: tely filled in by the	Certification:	4 Homicide determ		jor Roa	d / Highwa	ay		21123 Leiters	burg Parkway, Hage	rstown, Md.					
Divisior Within 24 hours after death whithin 24 hours after death To the Funeral Director: completely filled in by the		Collect Office	sician: To the best of miner:On the basis of exa												
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated				_icense number	and and and	29d. Date signed (M						
		Quiet?					O.C.M.E.		March 8, 2007						
		30. Name and address of person w	ho completed cause of c	death (Item	n 23a)	l									
12			stant Medical Exam			Street, Ba	Iltimore, MD	21201	<u>_</u>						
	tate		07 32. Registra	ar's Signati	ure	20	-								
Regis	ucli	FANLES OF C			-										

			1-	For State Registrar		State o	of Man	/land / [ealth a	and M	iental Hyg	giene Reg. No.	007	084	27	
			1. D	Decedent's Name (First, Middle	, Last)									2. Date of Dea Month	ath Day	Year	3. Time of	Death	
	Physici /Medio		1	Mary	Eliz	abetl	Bur	ns She	are	r				March	11,	2007	0212	2 A M	
	Examin		4a.	Facility Name (If not institution	_	eet and nu	m <i>ber)</i>			1		Location of	of Death			unty of Death	ר		
				Union Hospita							lkton		0.4.11			Cecil .			
	Funeral			ocial Security Number	6. Sex	и 2 0 F		n yrs. last bii	rthday) Yrs.	Months	r 1 Year Days	If Under:	Min.	8. Date of Birth (Month, Da)	h /, Yeer)	Col	nplace (State o untry)	ir Foreign	
	Director			13-03-5259		- X	88		115.					March 31	, 1918	Ma	ryland_		
	land		_	. State 10b. County			10	Oc. City, Tow	m or Lo	ocation							10d. Inside C	ity Limits	
	Mary	jo	Ma	ryland Cecil	1			E1kt	OΠ								1 🗆 Yes	2 📉 No	
	179 179 170 170 170 170 170 170 170 170 170 170	rec		. Street and Number				- LITICO	<u> </u>	10f. Zi	p Code				10g. Citizen	of What Co	untry?		
	3a ol	0		121 Elkside R	oad						21921				Uni	ted St	tates		
	death ms 2	Funeral Directo	11.	Marital Status		. Was Dec	edent Eve	r in U.S.	13.				gin? (Sp	ecify Yes or No- Rican, etc.)		Race - Amer	rican Indian,		
9	after or ft	T		1 ☐ Never Married 2 📉 Marri	ed	1 ☐ Yes If Yes, G	orces? 2 No			1 ☐ Yes		Specify:	i, rueito	ricari, etc.)		Black, White	9, OC.		
ဋ္ဌ	ours	d by		3 Widowed 4 Divorced		Year or [ates:				20110	Specify.				Wh:	ite		
21215-0036	72 h	Completed		15. Decedent (Specify only highes	's Educa it grade o	tion completed,		16a	. Dece (Give	dent's Usu	al Occupa	ation <i>turing</i> mosi))	t of work	ing		of Business/Industry bber Products			
7	Mithin 108.	dm	E	lementary/Secondary (0-12)		College	1-4or 5+))				ober Pi Lufacti		•	
7	iled v tygie thert	ပိ	17	Father's Name (First, Middle,	l ast)		<u> </u>	1	_ Su	perv	LSOI	18 Mothe	r's Name	e (First, Middle,			II THE		
and	ntal l	Be	A. J. M. D										e Fadele		ion camana,				
<u>Z</u>	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In marked other than "natural", or items 23a or 28a-f ehow umatic event, the Medical Examinar mast be notified at	ဥ	19a	a. Informant's Name/Relationsl		e, Print)	_	196	o. Maili	na Addres	s (Street a			al Route Numbe		own, State, Z	ip Code)		
Š	Ith ar			Donald I. She			and	12	1 F	lksi	le Ro	ad. F	:1kta	on, Mary	land	21921			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Michical Examinat mast be notified at ance.		20a	. Method of Disposition		·		20h. Place n	f Disno	sition (Na	me of		7-	Date 14,		ion - City or	Town, State		
Ë	Page ent o nt: H ry or			1 M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		noval from	State	Immacı Conce	úla	te			2007		Cherry	w Hill	, Mary	1and	
ati	mit.		21.	Signature of Funeral Service		1.		Conce	2:	Name a	nd Addres	s of Facilit	v						
m	Depa impo eny ir			Donned	8.	He	eks.		10	os W.	Home Sto	ror ckton	Fune Str	rals, P eet, El	.A. kton.	Marv1	and 219	921	
			23	a. Part1. Enter the disease, or shock, or heart failure. List	complica	tions that	caused the	e death. Do									Approximat Interval Bet	te	
E.	Physician	pt 7	Ima	mediate Cause (Final ease or condition	,	5	M	10 <	h	ml	•]	nset and	Death	
	/Medical		res	ulting in death)	(a.	Durin	(or as a c	onsequence	of):			1					77	\rightarrow	
В	Examiner		Sec	quentially list conditions	b	P	rei	1MO3	119	1	011	Nd					Dy		
J	pe tis	iner	if a	quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or injury	,	Due to	(or as a o	onsequence	of):	alit	75						1/21		
	and I-tran	хаш	tna	t initiated events ulting in death) Last	C.	Due to	(or as a c	onsequence	70	-110)						Luy	5	
8760,	law re-wires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ical Examiner				540 (6	(0, 00 0 0		0.,.										
687	phys phys s the	dic			d.														
Вох	certif nding use a	/We	IF FEMALE: 23c. If yes, outcome of pregnancy								23d. Date of delivery								
ă	death alter	ciar	23b. Was decedent pregnant in the past 12 months? 1												Month Day Year				
P.O.	that the death certific ed by the attending p detached for use as	Physician/Med		9 Unknown		9□ Unkr	iown												
	res tha signed I be det	by P	Part	t II. Other significant condition	ns contr	ibuting to	leath but n	ot resulting i	in the u	inderlying	cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of o	death?	
ë	w require been sig should b	ed		Demention	L									1 🗆 Y	es 2 N	lo 3 Pro	obably 4 🗆	Unknown	
000	e law regu has been ge 2 should	Completed		1x Y Derter	1510	W.								24a. Was autop	an 2	4b. Were au	topsy findings	available	
Œ.	Ti e ate h bage	E				, ,								perfo	rmed? 20%No	death?	_	4430 01	
ita	iicien: Ti certificate rector, pag	Be (Was case referred to medical examiner?								26. Place	of Deat	h Check only o	ne)				
<u>></u>	Physic this co	၉	-	1 ☐ Yes 2 No	Ho		Inpatient	2 ER/O	_			4 🗆 140			Residence 6 Other (Specify)				
n O	Attending Physicien: r death. ector: After this certified by the funeral director, to	e :		Manner of Death 1 ☑Natural 5 ☐ Pendin		28a. Date (Moi	of Injury oth, Day Y	ear) 28b.	Time o Injury		28c. Injun Worl			28d. Describe h	now injury o	ccurred			
sio	tend leath tor: / the f	cat		2 Accident investig				1		М		Yes 2 □	No	706 J time //					
Division of Vital Records,	or At after of Direct in by	Certification:		4 Homicide determ			e of Infury ling, etc. (- At home, fa Specify)	arm, st	reet, facto	ry, office			28f. Location (S City or Tox		u <i>mber</i> or Ru	rai Houre Nun	noer,	
	pital ours a erai i		299	a. Certifier1 Certifyin	a Physic	rian: To th	e best of n	ny knowleda	a daat	h occurre	t at the tim		d place	and due to the		d manner as	stated		
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Medical	236	(Check only 2 Medical one)	Examine	r: On the I	pasis of ex nner stated	amination ar	nd/or in	vestigatio	n, in my of	pinion, dea	th occur	red at the time,	date and pla	ice, and due	to the cause(s	3)	
	ombi	Me	29t	o. Signature and title of certifie	1.					29	c. License	e number			29d. Date s	igned (Monti	n, Day, Year)		
	- > F 0			· / //////	101	m	>				XIC	755	5		03/	12/2	007		
	1		30.	Name and address of person	who com	pleted cau	se of deat	h (Item 23a)	(Type,	Print)						-			
	()			ohn R. Mulvey,							te 3	09. E	1ktc	on, Marv	land:	21921			
X	Sta		31.	Date filed (Month, Day, Year)		3/9	Registrar's	Signature	1	N .							-		
	Registr	rar		MAR 1 6	2007	Bea	ALS.	15.	60	A Sent									

•			i ica		of Marylan						-	iene	0.00	00100	
		1	For State Registrar		,		tificate					Reg. No.		08428	
- W.A.	A part of		1. Decedent's Name (First, Middle								2. Date of Dea Month	ith Day	Year	3. Time of Death	
	Physicia /Medic		Josephine Sn	nith Shoc	key						March	10,	2007	9:30 P. M	
	Examin		4a. Facility Name (If not institution		u <i>mber)</i>		4b. City,		Location of			County of Deat			
			23200 Ringgold 5. Social Security Number	Pike 6. Sex	7. Age (In yrs. I	last birthday)	If Under		hsbu If Under 2		8. Date of Birt	h	Washing 9. Birt	hplace (State or Foreign	
*	Funeral Director		219-60-1628	1 □ M 2 X □ F	54	Yrs.	Months	Days	Hours	Min.	(Month, Da)	, Year)	Co	^{untry)} Maruland	
	70		Usual Residence of Decedent		10- 01-	. T								10d. Inside City Limits	
	show		10a. State 10b. County		Tuc. City	y, Town or Lo		a	7 7					1 ☐ Yes 2 ☐ No	
	the M	9	Maryland Wasi 10e. Street and Number	hington			10f. Zip		hsbur	9		10g. Citiz	en of What Co	41	
	3a or		23200 Ringgold	Pike				2	1783				U.S.A		
	death ma 2:	Funeral	11. Marital Status		cedent Ever in U.	S. 13.	Was Deced			gin? (Spec	cify Yes or No- Rican, etc.)	. 1	4. Race - Ame Black, Whit		
9	or its	V Fu	1 Never Married 2 Marr	ied 1 🗆 Yes	2 ∑ No Give		1 Yes 2		Specify:		,		Specify:		
Ö	hours tural',	ed by	3 Widowed 4 Divorced	Year or	Dates:		dent's Usua		ntion		1	16b. Kin	WI d of Business	nite Industry	
7	in 72 n "na'	Completed	(Specify only highes	it grade completed		(Give	kind of wor DO NOT us	rk done a	uring most	t of workin	ig .			,	
212	d with giene.	mo.	Elementary/Secondary (0-12)	College	(1-4or 5+) 4		Tead	cher					ducatio	on	
p	be filed within 72 hours after death with the Maryland and bygiene. d other then "natural", or itema 23a or 28a-f show event, the Medical Examinar must be notilified at	Bec	17. Father's Name (First, Middle,	Last)					18. Mothe		(First, Middle,				
yla	Ment Ment Marke Marke	ဂ္	Herman S. Smi		y A. We			Zin Codo)							
Nar	12 sh h and 7 is m traum		19a. Informant's Name/Relations		ichand)		•						Town, State, I arulan	d 21783	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at once.		James N. Shock 20a. Method of Disposition	ey (no	usband)	Place of Dispo	sition (Nan	ne of	al l	D	ate		ation - City or		
OLL	Pages ent of t: If i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		m State	ithsbu			· .	Marci 20	h 12,	Smi	thsbur	, Maryland	
alti Ei	mit. I partm portal y inju	1	21. Signature of Funeral Service			2:	2. Name an	d Addres	s of Facilit	y	12	525	Bradbu	cy AVe.	
<u>m</u>	8 G E E 8		John Lee	Davis	M0141								burg,Mo		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause or	t caused the death	h. Do not en	1				r respiratory a	rest,		Approximate Interval Between Onset and Death	
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	/Medical Examiner		rosuling in assum,	Due t	to (or as a conseq	uence of):								C	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ——Due t	to (or as a conseq	uence of):									
7	cuted od ransit	Examiner	that initiated events	S											
,092	eath certificate be executed attending physicien and for use as the burial-transit		resulting in death) Last	Due t	to (or as a conseq	uence of):							!		
6876	cate b	dicai		d											
9 X	The law requires that the death certifica sie has been signed by the attending phoage 2 should be delached for use as th	by Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy									2	23d. Date of delivery		
Вох	death a atter d for L	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	⊒Ectopic pr ⊒ Other <i>(sp</i>					Month Day Year						
P.O.	that the death red by the atter detached for u	hys	9 Unknown	9□ Un	known										
	signed l		Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	underlying c	ause give	en in Part I.		23e. Did t			o the cause of death?	
ord	v requir been s should	eted									-		1		
Records,	has t	Completed										osy ormed?_	prior to death?	utopsy findings available comptetion of cause of	
Vital		ပိ	25. Was case referred to medica	1					26 Place	of Death	1 Yes		1 L Yes	3 2 □ No	
Š	ysician: is certific director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hogostal	☐ Inpatient 2 ☐] ER/Outpatie	nt 3 DC	Oth Oth					Other (Spe	ecify)	
n of	Attending Physician: r death. sctor: After this certifics by the funeral director,		27. Manner of Death 1 ⊠Natural 5 □ Pendi		te of Injury onth, Day Year)	28b. Time o	of 2	28c. Injur Wor	y at k?	2	28d. Describe				
sio	tendii leath. tor: A the fu	catio		gation	A. b.		M		Yes 2 🗌		29f Location /	Street an	d Number or F	ural Route Number.	
Division	or At after of Direction by	Certification:	4 ☐ Homicide determ		ace of Injury - At h ilding, etc. <i>(Speci</i> i		reel, racion	y, omca			City or To			ara riodio riambor.	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyi	ng Physician: To	the best of my kno	owledge, dea	th occurred	at the tin	ne, date ar	nd place, a	and due to the	cause(s)	and manner a	s stated.	
	n 24 h	ledicai	(Check only 2 Medical one)	Examiner: On the	e basis of exa <i>m</i> ina anner stated.	ation and/or i	nvestigation	n, in my o	pinion, dea	ath occurr	ed at the time,				
	To t	Σ	29b. Signature and title of county				29	c. Licens	e number	Er	~	29d. Dat	e signed (Mon	100	
			100	//				1)	20	00	0	111	sch	16,2007	
	6		30 Name and address of person	who completed ca	ause of death (ter	m 23a) (Type	Print)	is)	The	Ha	30/100	11-	MD Z	162001 21742	
. 6	St	ate	31. Date filed (Month, Day, Year	32	. Registrar's Sign	ature	8, 3	-	, , _	. (- 1	July 1	1.00			
	Regist		MAR 1 6 2	007 Sea	Was B.	A CONTRACTOR OF THE PARTY OF TH	5.3								

			1 - For State Registrar	State of M	laryland				ealth a Death	nd Me		iene	000		84	29	
	Discolati	4	1. Decedent's Name (First, Middle, Last,							1	2. Date of Dea		Year		. Time of		
	Physici /Medio		John Joseph Sieben	kas							MARCH	Day 3	200		8:04	Рм	
h	Examin	er	4a. Fecility Name (If not institution, give St. Mary's Hospita]	Leonar				4c. County of Dea St. Mary							
	Funeral Director		123 34 4023	7. A	ge (In yrs. I.	ast birthday) Yrs.	If Unde Months	1 Year Days	If Under 2	Min.	B. Date of Birth (Month, Day May 16,	0	nthplace country) ry1ar	(State of	r Foreign		
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Lo	cation							10d.	Inside Cit	ty Limits	
	Maryl -f eho	tor	Maryland St. Mar	y¹s				Ho1	lywood				1 ☐ Yes 2% No				
	th the	Director	10e. Street and Number				10f. Zi	Code			1	0g. Citiz	en of What C	ountry?	,		
	ath wi		24501 Mt. Pleasant Roa					2063					USA				
136	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Madical Examiner must be notilised at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	ned Forces? If]Yes 2 □ No es, Give 1			dent of Hi cify Cuba 2⊠ No	spanic Origi n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White				
ş	r2 hou	ted	15. Decedent's Edu	cation		16a. Dece	dent's Usu	al Occupa	ntion	of working	2	16b. Kin	d of Business	s/indust	ry		
7	ithin 7	Completed	(Specify only highest grad	College (1-4or	5+)	life.	(Give kind of work done during most of working life. DO NOT use retired) Electronic Technician						US Government Co				
2	Hygier Hygier ther ti		12 17. Father's Name (First, Middle, Last)	2		Electr	onic	rechni		's Name ((First, Middle, I	Maiden S	Sumame)				
Maryland 21215-0036	ld be f ental l ked of	To Be	Max Siebenkas						a DeRosa								
<u>a</u>	and M and M is mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State												de)		
, 2	and sealth m 27		Mary Lou Siebenkas / Wife 24501 Mt. Pleasant Road Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City o											_	0		
2	Pages 1 nent of h ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	emetery, crer	matory or other place) an Crematory March 6, Alexandria												
Baitimore,	그런판을 .		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Line	to 0. " n		•			s of Facility	007	-						
ŭ	Depa Impo any l		Michael	Saroli	ner	M	latting	gley-G ox 270	ardine Leon	r Fune ardtov	eral Home wn, MD 20	P.A 650					
	Physician		23a. Part I. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that cause ne cause on each	line.		er the mo	1			respiratory arr			Int	proximate erval Betv iset and D	ween	
	/Medical Examiner		resulting in death)	Due to (or a		ience of):			5								
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as	s a consequ	ience of):											
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	01	1 d	ialy	515										
Ď,	ate be executed hysicien and the burial-transit	Ex	resulting in death) Last	Due to (or as	-												
6876U,	physic physic the b	o Severe PVD															
C. Box	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery Month Day			/ear		
2	uires that signed by id be deta	þ	Part in Other significant conditions contributing to death but not resulting in the discerning greates given in Fart.										se contribute to the cause of death?				
DIVISION OF VITAL RECORDS,	ysician: The law requir is certificate has been si director, page 2 should	Completed		<u>.</u>							24a. Was a autops perfori	y .	24b. Were a prior to death?			available ause of	
<u>Ea</u>	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	Check only on	-					
5	Physic this corral dire	၉	n Yes 2 No	lospital: 1 ☐ Inpat		ER/Outpatier			4 🗀 (Vul)		e 5 ☐ Reside			ecify)			
00	Attending Physician: r death. sctor: After this certific: by the funeral director,	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury	м	28c. Injury Work 1 □ `	at ? ∕es 2 □ N		3d. Describe h	ow injury	occurred				
DIVISI	al or Attendin after death. I Director: Af d in by the fur	Certification:	3 Suicide 6 Could not be 4 Homicide determined	ime, farm, str					28f. Location (Street and Number or Rural Route Number, City or Town, State)					ber,			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the bes ner: On the basis and manner s	of examinat	wledge, death tion and/or in	n occurred vestigation	at the tim	e, date and pinion, death	l place, ar	nd due to the c d at the time, d	ause(s) a ate and	and manner a place, and du	s state	d. cause(s))	
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	1			29	c. License		(~	2	9d. Date	signed (Mon	ith, Day	Year)		
			1 131	an			-	1 /	1706	06		3	· 4 -	0	/		
			30. Name and address of person who of	ompleted cause of EONARDTO			Print) 206	50									
	Sta	te :	AVANI D SHAH L 31. Date filed (Month, Day, Year)		trar's Signat	ture				<u> </u>							
·	Registr		MAR 0 5 200	17 6	. h	fra	Als s										

SIEBENKAS JOHN JOSEPH

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MÅRCH 4, □2007 **Physician** VERMA D. SIZEMORE 01:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month Day, Year) 03/28/1903 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F MD 220-01-8255 103 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at MD KENT MILLINGTON 1 ☐ Yes 2X No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 304 RACE STREET USA 21651 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLY LINE WORKER FOOD PROCESSING Item 27 is marked othe other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filment of Health and Mental Hant: if Item 27 is marked ott ANNIE "UNKNOWN" DEMON WILKERSON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEARL M. CLARK/DAUGHTER 605 BEDFORD LANE, NEW CASTLE, DE 19720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page
Department of
Important: if
any injury or
once. 03/10/2007 UNION CEMETERY GOLDSBORO, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEW 1370 CYPRESS STREET, MILLING I ant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 370 CYPRESS STREET, MILLINGTON, MD 21651 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No s certificate has b lirector, page 2 si autopsy 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) /2 No 2 ER/Outpatient ဥ 1 Yes 1 Inpatient 3 DOA this 27. Mannat of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Vithin 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated Signalure and title of o rtifie 29c. License number 29d. Date signed (Month, Day, Year) mo who completed cause of death (Item 23a) (Type ld. CDESTEDION 20

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registra

2007

			1 - For State Registrar	State of	Marylan		artmer rtificat			and M	lental Hy	/giene Reg. No.	007	0843	
×	Physici	20	1. Decedent's Name (First, Middle, Las	t)							2. Date of D Month		Year	3. Time of Dea	th
	/Medic		David Lee Short								Ma		, 200 ^{Year}	08:00 A	М
	Examir	ier	4a. Facility Name (If not institution, give	street and numi	ber)		4b. City,		rostbu				County of Dea legany	atn	
1		regio.	150 Frost Avenue 5. Social Security Number 6. Se	9x 7	. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under	_	8. Date of Bi (Month, D		9. Bi	rthplace (State or For	eigr
	Funeral Director			M 2□F	46	Yrs.	Months	Days	Hours	Min.		<i>ay, Year)</i> n 11, 19	3.40	ryland	
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IOTE, Maryland ZIZID-UU30 ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If them 2715 marked cother than "natural", or Items 23s or 28s-1 show the trainmails awant the Maryland Farming to August 18 and 1	arylar show dat	Ē	10a. State 10b. County			y, Town or Lo	ocation					10d. Inside City Lin			
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	with	ä	10e. Street and Number 150 Frost	Avenue			215					U.S.A		ourny.	
	ns 23	Funerai	11. Marital Status	12. Was Deced		.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ocify Yes or N		14. Race - Am	- American Indian,	
0	or ite	F	1 Never Married 2 Married	Armed Ford 1 Tes 2 If Yes, Give	No No		If Yes, spe		n, Mexican Specify:	i, Puerto	Rican, etc.)			ack, White, etc.	
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ary	2 should be and Mental Is marked (sumatic ev		19a. Informant's Name/Relationship (7				•		and Number or Rur						
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ore	t of H t of H if Iter or oth		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from St	ate	lace of Dispo emetery, crei	matory or o	other place			Date		cation - City o	aryland	
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g	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licen	Du	ret				s of Facilit Home,	-	ost Ave.,	Frostb	urg, MD	21532	
ļ	Physician /Medical		23a. Pan1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	used the deat	Sprza	ter the mod	de of dying	au such as	cardiac o	or respiratory	arrest,		Approximate Interval Between Onset and Death	
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.O. BOX C	death e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	□Ectopic pregnancy □ Other (specify)					2	3d. Date of d Month	Blivery Day Year				
ecords, P	The law requires that the ste has been signed by the bage 2 should be detached.	by	Part II. Dthar significant conditions of	agra	th but not res	utting in the u	nderlying (cause give	en in Part I.		23e. Did tobacco use contribute to the cau 1 ☐ Yes 2 ☒No 3 ☐ Probably				
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Z Z		BeC	25. Was case referred to medical examiner?		V				26. Place	of Death	(Check only	/ ·			
	Physic this ce al direc	To E	1 Yes 2 No			ER/Outpatier	nt 3 🗆 D	OA Othe	er: 4 □ Nu	ırsing Hoı	me 5 Res	sidence 6	Other (Sp	ecify)	
ō	ding Pl h. After th funera		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury		28c. Injury Work	C7		28d. Describe	how injury	occurred		
DIVISION	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director,	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	M reet, factor		Yes 2 🗍			(Street and own, State)	nd Number or Rural Route Number, e)					
	ne Hospita n 24 hours he Funera pletely fille	edical C	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam		is of examina										
	F S F O	ž	29b. Signature and title of certifier		-		29 //	c. License	number	C		29d. Date	e signed (Moi	nth, Day, Year)	
_	्यू।)	///			12	11	01	-1		3/1	107.		
p	w:DB		30. Name and address of person who	completed cause	of death (Item	n 23a) (Туре.	Print)	(en	+ Av.	e., (umbe	orla	nd, IV	10 2150	2
	Sta		31. Date filed (Month, Day, Year) 20	07 32.46	gistrar's Signa	ture				7			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Mark Gerard Souders 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Distribution (State or Foreign 8. Date of Birth (Month, Day, Year) Washington County Hospital Hagerstown 6. Sex 1 M 2 F If Under 1 Year 9. Birthplace (State or Country). Onio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 44 Director 210-54-0574 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f shormust be notified at 1 □ Yes Ž □ No Maryland Washington Williamsport Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15049 Terra Lane 21795 U.S.A. Funeral "natural", or Items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify. ð Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Tire Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Hayes Souders Doris Joanne Kelsey Hull ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trainonce. Deborah K. Souders (wife) 15049 Terra Lane Williamsport Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery March 7 07 Hagerstown Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) as been signed by the 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes No r this certificate har ral director, page 2□No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director To Be 26. Place of Death (Check only one) Other: 1⊈Yes 2 No 2 ER/Outpatient 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 2 □ No 1 TYes neral Director: A filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

31. Date filed (Month, Day, Year) MAR 0 6 2007

29b. Signature and title of certifier

Omi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ma

32. Registrar's Signature

251

29c. License number

130056969

29d. Date signed (Month. Dav. Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Registrar	State of Maryla		artment of I			ene 007	08433
		^	1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici		Helen	Virginia	Smit	:h		March	3 200 ^{Year}	10:45 AM
	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Dear	th	4c. County of Death	
			Woodside Cente	r		Silver	Spring		Montgom	ery
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days			9. Birth	plece (State or Foreign
	Director		228 - 18 - 6324	M 2 1 99	Yrs.	Months Days	Hours Min	Dec. 28	1907 Ma	ryland
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	aryla •ho	5	,		•					10d. Inside City Limits 11 Yes 2 □ No
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	with or	늄	9101 Second Avenu	ie.		20910)	109	U.S.A.	ntry?
	2 should be filed within 72 hours after death with the Maryland and Mental Hydiene. and Mental Hydiene. is marked other then "nature!; or items 23e or 28e-f show eumatic event, it a Medical Enablinar must be notified at	by Funeral		12. Was Decedent Ever in	115 13			Specify Yes or No-	14. Race - Ameri	can Indian
	ter d	ᆵ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No		If Yes, specify Cub	pan, Mexican, Puer	to Rican, etc.)	Black, White	
ဗ္ဗ	urs a	b	3 ☐ Widowed 4 ☐ Xivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: Wh	ite
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פ	al Hygie d other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
<u>a</u>	should be and Mental I amarked or umatic eve	2	William Alvey S	Smith			Mi	nnie M.	Michael	
	and and in m	1	19a. Informant's Name/Relationship (Type		the second				City or Town, State, Zi	
	es 1 and 2 should bot Health and Ment i Item 27 ie marked r other treumatic e		Helen Smith - self				Second Av			, Md. 20910
altimore,	Pages 1 nent of H int: If ite iry or ott		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Re	emoval from State		natory or other pla	,		c. Location - City or T	
<u>ב</u>			4 □ Donation 5 □ Other (Specify)	1			ery 3/0		rederick,	
Ball	permit. Depertri Imports eny inju		21. Signature of Juneral Service Cicense	71.11	M	2. Name and Addre	ess of Facility 1-William	s P.A., Fi	uneral Hom	e
	<u>v</u> ∪ = • α	18	Trut L.	Muller	21	5401 Ridg	ge Road,	Damascus	, Maryland	20872
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the de se cause on each line.	eath. Do not ent	er the mode of dys	ng, such as cardia	c or respiratory arrest	1.	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Cand	10 mc	opath	29			i ears
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of): `~			2 ' 2 -		0
		1	Sequentially list conditions, b	Due to (or as a cons		tic -)-leant	Dise	ase	redul
	led Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence or):					-4
•	xecu and al-tra	хаг	that initiated events c. resulting in death) Last	Due to (or as a cons	equence of);					
8760	icate be executed physicien and s the burial-transit	dicai E							1	
89	titicate ig phy: as the	edic	0							
Box	Ine law requires that the death certifi Ite has been signed by the ettending t bage 2 should be detached for use as	Ž	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg					23d. Date of deliv	erv
Ď	Jeath ette	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time o		Ectopic pregnanc Other (specify) _	у		Month	Day Year
0	by the de	hys	9 Unknown	9□ Unknown						
J	w requires that been signed b should be deta	by P	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
Hecords,	quire n sig uld b	be be						1 🗆 Yes	2 ₹ No 3☐ Pro	oably 4 □Unknown
္ပ	s bee	Completed						24a. Was an	24b. Were auto	opsy findings available
ž į	r I ne lav cate has page 2	E						autopsy performe 1 ☐ Yes 21	prior to co	mpletion of cause of
		O	25. Was case referred to medical				26 Place of De-	1 ∐ Yes 2N_ ath Check only one]No 1□Yes	2∐ No
	ysich is cer direc	0	examiner? 1 Tes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatier	t 3 DOA Ott			ce 6 ☐ Other (Speci	64)
0 8	er thi	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)				28d. Describe how		77
0	death. ctor: After y the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 19ar)	Injury		rk?]Yes 2∐No			
Division of	- 0 D	i Li	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Run	al Route Number,
5	s after or s after or	Certification:		building, etc. (ope	cny/			City of Town,	olale)	
	• Hospitel 24 hours a • Funerel letely filled		29a. Certifier 1 Certifying Phys	ician: To the best of my k	nowledge, deatl	occurred at the til	me, date and place	e, and due to the caus	se(s) and manner as s	tated.
-	in 24 in 24 in 24 in 6 in 6	Medical	one)	er: On the basis of exami and manner stated.	nation and/or in	vesugation, in my o	opinion, death occi	urred at the time, date	and place, and due t	o the cause(s)
,	no the Hospitel of within 24 hours at To the Funerel Di completely filled in	Σ	29b. Signature and title of certifier	1100	y	29c. Licens		29d	. Date signed (Month,	Day, Year)
			Kayna	1100	(12	-0108	Ma	arch 5, 20	07
1	1/2		30. Name and address of person who con					01 -		00715
	1		Rakesh Arora M.				Suite 2	ZI, Bowie	, Maryland	20715
	Sta		31. Date filed (Month, Day, Year)	32. Rigistrar's Sig	nature d	parti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 07 TATTIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REGIONAL MEDICAL Wicamico ALLBURY 7. Age (In yrs. last birthday)
Yrs. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 220-32-888 10-2-2 Director Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 □Yes 2D **Funeral Director** NOW MD IN ORCESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and Mental Hygiene. Is marked other than "natural", or Items 23a or a aumatic event, the Medical Examiner must be r 21863 SA 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 9 -I AM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trauonce. SALISBURY Date 20c. Localid 1619-WICONIA DRIVE, 21861 MD -ORINDA KOBINS ~ DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State SNOW HILL N SMITH FIH AYLOR GATE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BENNIE SAL BBORY SABELLA ST. 2180 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Dianh To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown 3 Probably 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death. To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NeNDON egistrar's Signature 31. Date filed (Month, Day, Year) State MAR 05 2007 Registrar

Funer

Baltimore, Maryland 21215-0036

		State of Maryl State Registrar		artment of H		-	giene Reg. No.	07 08435
	OA.	Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
icia		Mary Elizabeth Thompson				Month	2. 2007	7:20 a.M.
dic. nine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De			y of Death
		St. Mary's Nursing Center		Leonardt	own		St. M	fary's
ai		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)		If Under 24 H		h	Birthplace (State or Foreign Country)
or		579-18-3495 1□ M 2\QF 85	Yrs.	Months Days	Tiodis IV	02/06/1	922	Washington, DC
		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	neation				10d. Inside City Limits
	_	1,						1 □Yes 2X1No
	sctc	mary and ser	eonardto				10 022	
	ä	10e. Street and Number		10f. Zip Code		I	United	What Country?
	Funeral Director	23670 Rocky Ridge Court	-11.0	20650	ionania Ovinia			ce - American Indian,
	ž,	11. Marital Status 1 Marver Married 2 Married 1. Mas Decedent Ever i Armed Forces? 1 ☐ Yes 2 No	n 0.5.	If Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		ack, White, etc.
	Ş	3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specia	_{fy:} White
	ed	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of B	Business/Industry
İ	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of (d)	working		
	Completed by	2	Admi	nistrativ	e Assis	tant	U.S. G	Government
	Be	17. Father's Name (First, Middle, Last)			18. Mother's I	Name (First, Middle,	Maiden Surnai	me)
	၉	Burton Emory Thompson			Lillia	n Frances	Richar	cdson
		19a. Informant's Name/Relationship (Type. Print)				Rural Route Number		
		Ralph Lee Thompson/ Brother						, MD 20650
		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State	 b. Place of Disponentery, cre 	osition (Name of matory or other plac	e)	Date	20c. Location	- City or Town, State
		4 □ Donation 5 □ Other (Specify) B:		d-Echols		07/2001		te Hall, MD
ouce.		21. Signature of Funeral Service Licensee Kyle S. Simons M01206	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	2. Name and Addres	ss of Facility I	Brinsfield oad, Leon	l Funera ardtown	al Home, P.A. , Maryland 20650
ø.		23a. Part1. Enter the disease, or complications that caused the c						Approximate
		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	12.00	Tool I	5.0	DA		Interval Between Onselland beath
al		disease or condition resulting in death) Due to (or as a con	sequence of):	ory 1	una	1000		and the second
er		Co	mass	(We	Hear	tack	us	wor
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):	1/2	1	7		410
	Examiner	that initiated events c.	200ra	24/7/21	24	LE.		423
	ũ	resulting in death) Last Due to (or as a con	sequence ot):					
	dical	d		1				
	Me	IF FEMALE: 23c. If yes, outcome pf pre	eanancy				004 D	-1612
	ä	in the past 12 months?	etal death 3	☐Ectopic pregnancy ☐ Other (specify)	1			ate of delivery onth Day Year
	Physician/Me	1 ☐ Yes 2 ♣No 9 ☐ Unknown 9 ☐ Unknown	or double of					
	4	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to the cause of death?
1	۵	CA 11	20			_ 1_1	res 2 No	3 ☐ Probably 4 ☐ Unknown
	ete	I Demantio - 4	Adhie	rock!	in	24a. Was	an 24b.	Were autopsy findings available
	Completed by		7	nun			rmed?	Were autopsy findings available prior to completion of cause of death?
	ပိ	25. Was case referred to medical			26 Place of I	1 Yes Death (Check only o	2 No	1 ☐ Yes 2 ☐ No
	To Be	examiner?	2 ☐ ER/Outpatier	nt 3 DOA Othe	er:	g Home 5 ☐ Resid		her (Specify)
		27. Manner of Death 28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. injur		28d. Describe h		
	atio	2 Accident investigation	, injury		Yes 2 □ No			
	rtific	3 Suicide 6 Could not be determined 28e. Place of injury - A building, etc. (Sp	t home, farm, str <i>ecify)</i>	reet, factory, office		28f. Location (S City or Tox	Street and Numi vn, State)	ber or Rural Route Number,
	ခ် ပ	29a. Certifier 1 2 Certifying Physician: To the best of my	knowledge deat	h cocurred at the tir	no data and al	and due to the	navian(a) and m	anner en etated
	Medical Certification:	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.						
	Ž	29b. Signature and title of bertifier	1/2 N/	29c. Licenso	e number	419	29d. Date signe	ed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	100	4	0 -	
)		James P. Jarpoe, M.D., 24035	Three No		Holly	wood, Mary	land	20636
Stat	•	31. Date filed (Month, Day, Year) 3 Registrar's S	ignature	ale				
				-				

		1	For State Registrar	·	Cer	tificate of E	Death		Reg. No. 2	07	081	:36
	Physicia		1. Decedent's Name (First, Middle, Last)	T				2. Date of Dea Month	Day	Year	3. Time of	Death P M
	/Medic	al	John Ernest Thomp 4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Death	Februa	ry 27, 2	2007 of Death	4:40	
	Examin	er	Baltimore Washingt	on Medical Cer	nter	Glen E	Burnie				Arunde	
	Funeral Director		5. Social Security Number 6. Sex 13.	7. Age (In yrs. last	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 1	0, 1922	Cour	olace (State on otry) nection	_
1	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loc	ation				1	I 0d. Inside Ci	ity Limits
	Maryla a-f shov ified at	ctor	Maryland Anne Aru			Annar	polis					2 X No
	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural"; or Items 23a or 28a-f show an anatic event, the Medical Examiner must be notified at	al Director	10e. Street and Number 1111 Little Magoth	y View		10f. Zip Code	21409		10g. Citizen of W	S.A.		
	ems 2	Funeral	11. Maritai Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Blac	e - Amerio k, White,	etc.	
326	al", or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: WW II	1	☐ Yes 2 🙀 No	Specify:		Specify	: Wh	nite	
5-0036	72 hou natura ilcal E	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	lent's Usual Occupa	ation furing most of work)	ing	16b. Kind of Bu	siness/In	dustry	
121	within ane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Product Ma			Fo	ood		
2	filed v Hygie other 1	ပ္ပ	17. Father's Name (First, Middle, Last)			1	18. Mother's Name			ie)		
<u>lan</u>	9 5 5 5 P	To Be	John Ernest Thomp	oson, Sr.	_			t Ferri			-	
Maryland 21	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type Vivienne F. Thomp				and Number or Rur agothy Vi		er, City or Town, apolis,		21409	
altimore,	ges 1 and 2 t of Health a If item 27 is or other trat		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other place	e)	Date	20c. Location -		_	
Ĕ	permit. Pages Department of I Important: If its any Injury or o		4 □ Donation 5 □ Other (Specify)	Ft.			tory 3/1/		Brentwoo		Contract to the	
Ba	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	aren			f Glouces					
N			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approxima Interval Be Onset and	tween
Ų	Physician		Immediate Cause (Final disease or condition	Parkinson	s Dise	ease					Oriset and	Deani
۲	/Medical Examiner		resulting in death)	Due to (or as a consequent								
	is in	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence)								
	cuted id ransit	Examiner	Cause (Disease or injury that initiated events	Skin Canc								
90,	rtificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):							
68760,	ficate I physi s the b	Medical		1.								
Вох	law requires that the death certii as been signed by the attending 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	<i>y</i>			te of deliventh	very Day	Year
, P.O.	that the		Part II. Other significant conditions co	ntributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use con	ribute to	the cause of	death?
rds	w requires been sign should be	ed by						1 🗆	Yes 2 No	3 ☐ Pro	obably 4X	JUnknown
or Vital Records,	The law re ate has be bage 2 sho	Completed						24a. Was auto perf 1□ Yes	ppsy ormed?	prior to c death?	topsy findings ompletion of 2 \(\subseteq \text{No}	s available cause of
ţa		BeC	25. Was case referred to medical examiner?				26. Place of Dea					
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ono	Te fe	tion:	27. Manner of Death ★XNatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2∐No	200. 200050	non ngary seesa.			
Division	or Attending ifter death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hos building, etc. (Specify	me, farm, st	reet, factory, office			(Street and Numi own, State)	per or Ru	ral Route Nu	mber,
	To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	vsician: To the best of my know Iner: On the basis of examinat and manner stated.	wledge, dea tion and/or in	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to the	e cause(s) and m e, date and place,	anner as and due	stated. to the cause	e(s)
	Fo the within ?	Med	29b. Signature and title obsertifier			29c. Licens			29d. Date signe			
			1 50	Breeze	~	R	D 45149		Februar	у 27 ——	, 2007	
,	411		30. Name and address of person who c				Rurnie A	farul and	20161			
	ST	ate	Dr. Bolaji Onabaj 31. Date filed (Month, Day, Year) MAR 0 1 2	32. Segistrar's Signa	ture		Durine, I	wr Arail	20101			
	Regist		MAR 0 1 2	1007 Been 1	N 1	Goodh 1						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Martha Ella Thorne March 10, 2007 9:22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Julia Manor Healthcare Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F Yrs. 81 Director 220-18-3293 Nov. 11, 1925 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 10b. County 1 TYes 2 No Director Maryland Washington Sharpsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code P.O. Box 117 / 112 S. Mechanic St. 21782 U.S.A.Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2X No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Cook 12 Restaurant other traumatic event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is merked othe any injury or other traumatic event, 2008. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Allen Grafton McGraw Edith Verbelle Bender ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1782 19a. Informant's Name/Relationship (Type, Print) Vernon G. Thorne (Husband) P.O. Box 117 / 112 S. Mechanic St. Sharpsburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition March 12 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsbur Crematory Smithsburg, Maryland 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 MO1414 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 M MNEX Caucer /Medical Due to (or as a dor sequence of): Examiner Myoniz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Wb. -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the buriat-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 AProbably 4 □Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 1 ☐ Yes 2 ☐ No this certificate 2 No After this certific funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P52323 03-12-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d 1126 Opal Crt. Hagerstown, Maryland 21740 Waseem 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	10000	State	of Mary	/land		artmen rtificat				lental H	Reg. No			08438
	Physici	an	Decedent's Name (First, in the content of the	Middle, La	ist)								2. Date of D Month MARCH	eath Day	у Хөд	07	3. Time of Death
	/Medi		Eleanor Hen										MARCH				09:55А м
	Examir	ner	4a. Fecility Name (If not inst			umber)					Location	of Death			County of D		
			St. Mary s 5. Social Security Number		Ltal Sex	7. Age (In	n vrs. las	it birthday)		nardt 1 Year	If Under	24 Hrs.	8. Date of B		t. Mar	Birthpla	ice (State or Foreign
	Funeral Director		410-32-5917		1 ☐ M 2 🗓 F	1.7.95 (83	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, L 09/30	/1923	Mi	Counti SSO	uri
			Usual Residence of Decede													1	
	anylar show	_	10a. State 10b. Co	ounty	_			Town or Lo								10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
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	with ti	吉	10e. Street and Number	1 1	D 1				10f. Zip								
	U.30 burs after death with the Maryland raf, or items 23a or 28a-f show Examinational terretified at	Funeral	48791 Havir	Land	12. Was De	cedent Ever	r in U.S.	13. \		0653 dent of Hi	ispanic Ori	igin? (Sp	ecify Yes or N Rican, etc.)		ed Sta	merica	n Indian,
	fler d	표	1 Never Married 2	Married	Armed F 1 ☐ Yes	Forces?							Rican, etc.)		Black, W		
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2	within 900.	m	Elementary/Secondary (0			(1-4or 5+)		_	DO NOT us	se retired	1)			Cir	il Ser		
111	filed v Hygie other t	ပိ	17. Father's Name (First, Mi	iddle. Lasi	t) Z			Secre	cary		18. Moth	er's Name	e (First, Midd			VIC	: e
.0	d be in the control of the control o	To Be	John Willia								Arme	nta	Perry				
3	Baltimore, Maryland ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after dea Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items any injury or other traumatic event, the Mexical Examination once.	F	19a. Informant's Name/Rela					19b. Mailir	ng Address	(Street a			al Route Num	ber, City o	or Town, State	e, Zip (Code)
	nd 2 alth a 27 to		Sharon Harwo	od/ I	Daughte	r		P.0	. Box	838	, St	. In:	igoes,	Mary	land 2	068	4
W	ore, M es 1 and 2 of Health of Health ritem 27 l		20a. Method of Disposition 1 X Burial 2 ☐ Crema	ation 3	Removal from		20b. Plac cen	ce of Dispo netery, cren	sition (Nar natory or o	ne of ther plac	:е)	t	Date	20c. L	ocation - City	or Tov	vn, State
8	Pages nent of I		4 Donation 5 Oth				Firs	t Fri	endsh	ip U	IMC C	3/10	/2007	Ridg	ge, Ma	ry1	and
4	Saltimore, permit. Pages 1 at Depertment of Hea Important: if item any injury or othe		21. Signature of Funeral Se		//-		me	_	2. Name an			. DL					ne, P.A.
			Kyle S. S: 23a. Part1. Enter the disea												own, l		yland 2065(Approximate
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4	HECONOS, P.O. BOX 68/ The law requires that the death certificate the hes been signed by the ettending phystage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 M No 9 ☐ Unknown			birth 2 and gnant at time] Fetal d	leath 3[Ectopic pr		'				23d. Date of Month		y Day Year
	dS, F uires thet signed b	d by PI	Part II. Other significant co	onditions	contributing to	death but n	ot result	ing in the u	nderlying c	ause give	en in Part	I.			use contribut		cause of death?
ELEANOR RO	OT VICAL RECORDS, Physician: The law requires? rthis certificate hes been signed. rail director, page 2 should be	Completed	UTI	entic									24a. Wa aut per 1 Yes	opsy formed?	prior death	to com	sy findings available indicate of
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급;	OT VICA Physician: rthis certific ral director.	10	1 ☐ Yes 2 ☐ №6		1			R/Outpatier			4 🗆 🖂	ursing Ho	me 5□Re			pecity,)
MO	on or ding Phy h. After thi funeral o	ü		Pending		e of Injury onth, Day Ye	ear) 2	28b. Time of Injury		28c. Injun World			28d. Describ	e how inju	ry occurred		
MCTOM	SION ttending death. tor: After the funer	catl	3 ☐ Suicide 6 ☐ C	ould not	be 200 Play	ce of Injury	- At hom	o farm et	M root factor		Yes 2	INO	28f. Location	(Street at	nd Number o	Rural	Route Number,
. n	INISION i or Attending efter death. Director: After iin by the fune	Certification:	4 Homicide	determined	d buil	Iding, etc. (S	Specify)	10, 141111, 511	eet, lactor	y, onice				own, State		, , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	LIVISION OF VICE To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Ce (Check only 2 Me	rtifying P	Physicien: To the miner: On the and ma	he best of m basis of exa unner stated	aminatio	ledge, deat on and/or in	h occurred vestigation	at the tin	ne, date a	nd place, ath occur	and due to the	e cause(s e, date an) and manner d place, and	as sta	ited. the cause(s)
	To th To th comp	Me	29b. Signature and title of c	ertifier /	N N	W			290	c. Licens	e number	27		29d. Da	te signed (M	onth, C	Day, Year)
	10;m		30. Name and address of p	\		use of death				D 20	1622						
	St. Regist	ate rar	31. Date filed (Month, Day,	Year)	32.	Registrar's		re	nek)								
			MAR.	U.J.	23	1000000	180	A STATE OF THE PARTY OF THE PAR	- All Bring								

State

Registrar

12821-

OAKHIL AVE HAGERSTOWN. MD 21742

who completed cause of death (Item 23a) (Type, Print)

32. Fegistrar's Signature

un -

NAHERD

MAR 0 6 2007

31. Date filed (Month, Day, Year)

07-01814 Queenie Vaughan Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

rueeme vaugna	1	1. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death	17 08440
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last) Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	3. Time of Death 1530 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	eath
	4	Prince George's Hospital Center Cheverly Cheverly Prince George's Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Security Number 1. Security Number	
Funeral Director		224-38-2772	preign Countrivirginia
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d Inside City Limits
Maryland 28a-f show any <u>d at once.</u>	ğ	Maryland Prince George's Forestville	1 Yes 2 XXNo
th the Maryland 23a or 28a-f sho notified at once.	Dire		country?
death wi	by Fune	Wildowed 4 XX Divorced in Yes, Give Year or Dates:	Black
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Private Duty Nurse Med	ical
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co		
MD 21 id 2 should lith and Mei m 27 is mai	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Support Power of Pow	
e, M I and 2 Health Titem 2	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - Ci	
Baltimore, permit. Pages I an Department of Hea Important: If itee		4 Donation 5 Other Specify: Resurrection Cemetery 03/13/2007 Clinton	, Maryland
Balt permit. Depart Import injury	4	21. Signatur of Funeral September 22. Name and Address of Facility George P. Kalas Funeral 6160 Oxon Hill Road Oxon Hill, Maryland	20745
Physician /Medical		23a. Part I. Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filure.	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardi menuty with biventricular hypertro by and ather coloratic cardiovascular disease	
	je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
nsi ig	Medical Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (Specify)	ivery Day Year
. Boy he death y the att	hysi	1 Yes 2 No 9 ✓ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribution	e to the cause of death?
rds, P.O. requires that the been signed by hould be detach	d by	Terminal renal disease	Probably 4 Unknown
Records, F The law requires cate has been sign	Completed by	24a. Was an autopsy prio dea 1 ✓ Yes 2 No 1 ✓	e autopsy findings available to completion of cause of th? Yes 2 No
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Division of Vital plus or Autending Physician: ours after death. Are this certifiled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number of Town, State)	r Rural Route Number, City
Division To the Hospital or Attenti within 24 hours after death. To the Funeral Director: /			stated. to the cause(s)
To To Com	Medical		(Month, Day, Year)
		O.C.M.E. March 8, 200	/
ų.		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St Regist	ate	MILLER / 110 15 M ME 200 1 M M M M M M M M M M M M M M M M M M	

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 7:45 P 2007 Rita Florine Wible March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 👿 F Yrs 80 June 19, 1926 Director 213-22-2294 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No California Director St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ' USA 20619 44693 White Oak Court #519 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Agnes Florine Raley Edwin Parran Johnson 2 of Health and Nitem 27 is mai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 44693 White Oak Court #519 California, MD 20619 Mary Reeder / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If ite any Injury or ot 1 Surial 2 ☐ Cremation 3 ☐ Removal from State March 5 Charles Memorial Gardens Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility 21. Signature of Fungral Service License Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part V. Enter the disease, or com shoot or heart failure. List only complications that caused the death. Do not exthe mode of dving, such as ordiac or respiratory arrest one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a Division or Vital Records, P.O. Box 68760, attending physiciar Physician/Medical as t IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Feta! death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Linknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has autonsy page 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 2 No 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Injury 1 PNatural 1 TYes 2 □ No 2 Accident within 24 hours after death To the Funeral Director; the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print) James P. Jarboe, M.D. Hollywood, MD 20636 24035 Three Notch Road 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

07-01602 Kenneth James	Wal		oe or Print in B l ate of Maryland							1 00116
		1- For State Registrar	ato or maryiana		ificate of D		· Worker		g. No.	1 08442
Physicia Medical Exami	3	1. Decedent's Name (First, Middl Kenneth	J.		Walter			Date of Death Month February 2	Day Year 27, 2007	3. Time of Death 0707 hrs
	12	4a Facility Name (if not institution 21610 Liberty Street A)		city, Town, or I exington Pa	Location of Death ark		4c. County of Death St. Mary's	
Funeral Director		5. Social Security Number 101–66–3647	6. Sex 7. Ag	ge (In yrs. Ias 24	-	Under 1 Year Ionths Days			er 5, Foreig	thplace (State or InNew York untry)
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		arried 12. Was Decedent Armed Forces' 1 X Yes 2 orced or Dates:	? No	If Yes, s	specify Cuban, $2 \left[f{X} \right]$ No	Mexican, Puerto		White, etc. Specify: W.	can Indian, Black, hite
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1215-0 d be filed w ental Hygie arked othe vent, the N	Be	17. Father's Name (First, Middle, Guy K. Walter					Cynth	(First, Middle, Middle, Es	posito	
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imore, Pages I an nent of Hea lant: If iter		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Sy	pecify:	ate cr	ace of Disposition ematory or other p opolitan (olace) Cremator	Mar	Date ch 6, 2007	20c. Location - City or Alexandria,	
Balt permit. Depart Import injury		21. Signature of Funeral Service Multiple Amount Am	Dardy.	nev	P.O.	Box 270	Leonar	uneral Hor dtown, MD	20650	
Physician /Medical Examiner		23a. Part I. Enter the disease, on failure. List only one cause immediate Cause (Final disease	on each line. a. Gunshot Woun	ds of the	Head	ode of dying,	such as cardiac c	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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Division Rospital or Attendit 24 hours after death Funeral Director: A	Certification:	3 Suicide 6 Cou		njury - At hor	me, farm, street, fa	ctory, office b	uilding, etc.	or Town, St	treet and Number or Ru tate) Street Apt. 002, Lexi	
Dir To the Hospital Within 24 hours a To the Funeral I	Medical C	29a. Certifier 1 Certifying P	hysician: To the best of n miner:On the basis of exa and manner stated	amination and	e, death occurred d/or investigation,	at the time, da	ite and place, and death occurred a	d due to the cause at the time, date a	and place, and due to th	e cause(s)
	Me	29b/Signature and title of certific				29c. License O.C.			29d. Date signed (Mo February 28, 200	
13 m		30. Name and address of persor Laron Locke MD. A	who completed cause of ssistant Medical Ex	•	^{23a)} 111 Penn St	reet, Baltin	nore, MD 212	201		
S Regis	tate trar	31. Date filed (Month, Day Year)			S. Sp	who				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Wright Anna Hyndman 2007 March 6, /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner

8:30 A M St. Mary's Bayside Nursing Center Lexington Park If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2X F 02/21/1931 New York 108-22-1733 76 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No notified Directo Maryland St. Mary's Lexington Park 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. 21214 Greatmills 20653 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes **3** No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hyndman James Sarah Hyndman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45265 Cal Acres Lane California, Maryland 20619 Karen Wright Ladner / Daughter altimore, 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Cre 03/09/2007 | Charlotte Hall, MD. 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Brinsfield Funeral Home PA. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year Por in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ∃Yes P.0. ed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertorm 2 100 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4D Nonsing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No nours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a. Certifier Medical completely 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Boyd, 23415 Three Notch Road California, Maryland MD 32 Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 2, ^D2007 **Physician** 10:15 A M SCOTT LANSING WILLIAMS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** HERON POINT CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth 02/21/1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F OK 448-09-7729 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 77 ie marked other than "natural", or Itams 23a or 28a-f ehow traumatic event, the Modical Examinar i ust be notified at YYes 2 □ No MD KENT CHESTERTOWN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 313 HERON POINT Be Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) GOVERNMENT METEOROLOGIST 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 1e marked othe any injury or other traumatic event, 0008. 18. Mother's Name (First, Middle, Maiden Sumame) MARY ELANDER ROBINSON J. DON WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 HERON POINT, CHESTERTOWN, MD 21620 MARY ELLEN WILLIAMS/WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 03/03/2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee 23a. Port1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Be Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 🗌 Yes 28b. Time of 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Medicai 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. 29c. License number 29d. Date signed (Month, Day, Year) ပ္ 120060301 who completed cause of death (Item 23a) (Type (Int) Ki) 5785 30. Name and address of person MICHAREZ 31. Date filed (Month, Day, Year) State Registrar MAR 05

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ō,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or iteme 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once.		PATRICIA MARSHALL/ 20a. Method of Disposition	DAUGHTER	20b. Plac	e of Dispo	sition (N	ame of		Date		Location - City or	
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υ U	t and Healt em 2 ther	5 8	Rosalie H. Weller - Wife 20a. Method of Disposition	20b. Pla		00 Ches		t Grov	e Ko			tick, Ma		-
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2	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (ne, farm,	, street, factor,	, office		28f	Location (St. City or Town	reet and l , State)	Number or Rura	al Route Number,	
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	To the Hospital or Attending Physician: The law requires that the divibing Value after thous after death. Within 24 Hours after death. completely filled in by the funeral director, page 2 should be detached	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of r 2 ☐ Medical Examiner: On the basis of eight one) and manner state.	xaminatio	ledge, d on <mark>an</mark> d/o	eath occurred or investigation	at the tir , in my c	ne, date and pinion, death	place, an occurred	d due to the ca Lat the time, da	ause(s) a ate and p	nd manner as s lace, and due t	tated. o the cause(s)	
	thin 2	Med	one) and manner stated	a.		290	. Licens	e number		20	9d Date	signed (Month,	Day Voar)	_
	F > F 8		Alan H Kolirer	MI	DT		D3 71			2		ch 1, 20		
•	(0)	-	30. Name and address of person who completed cause of deal											_
	11		Alan H. Rohrer, M.D., D.M.	E.,	15 T	West Se	even	th Str	eet.	Freder	ick.	Marvla	and 21701	
	Sta	te	31. Date filed (Month, Day, Year) 32. Legistrar's	s Signatu	TE.	1 .					,	,		-
	Registr	_	MAR 0 5 2007	U 1	F	marke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.2

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

Wascem

31. Date filed (Month, Day, Year) NAR 06 32. Registrar's Signature

1126 OPal Court

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

Hagerstown, Maryland

29d. Date signed (Month, Day, Year)

Physician Wanda P. Ashley 12, March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Ctr. Baltimore City If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 □ M 2 🔽 F 215-18-0927 Director 85 7, 1921 May Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location other traumatic event, the Medical Examiner must be notified at Dundalk Directo Maryland Baltimore 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a United States 21222 death v Funeral 1513 Vesper Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Be Completed by 3- Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 sho Id be filed within Department of Health and 1 ental Hygin ne. Important: If item 27 is marked other than 1 any injury or other traumatic event, it e M any injury or other traumatic event, it e M Elementary/Secondary (0-12) College (1-4or 5+) Nurse Aide Medical 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 1 nent of Health and Nental | Jadwiga Zakulska Julius Podbielski ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Polltimore. Maryland 21221 19a. Informant's Name/Relationship (Type. Print) Louis J. Rychwalski (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Injury or 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Polish National Cem. 3/16/2007 4 Donation 5 Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure_tist only one cause on each line. Part1. Enter the dis shock, or heart fall Immediate Cause (Final Physician ASCV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the bunal-transit Due to (or as a consequence of) Box 68760. physician death certificate be Physician/Medical for use as IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 ☐ Other (specify) signed by the a d be detached for P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an has autopsy The After this certificate 1☐ Yes 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3 DOA ဥ 1 🔲 Inpatient 2 ER/Outpatient funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day Year) Injury 5 Pending investigation within 24 hours after death. To the Funeral Director: A: completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

For State Registrar

1. Decedent's Name (First, Middle, Last)

Registrar DHMH 17 Rev 1/2001

To the Hospital

29a. Certifier

80. Nam

(Check only one)

29b. Signature and title of certifier

31. Date filed (Mohth, Day, Year)

Medical

State

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

do se m

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Day

Year

14. Bace - American Indian. Black, White, etc.

Specify:

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

mD 21224

Month

8:43

10d. Inside City Limits

White

Dundalk, MD

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

N/A 9. Birthplace (State or Foreign Country) Maryland

2007

4c. County of Death

Certification: To funeral Medical

certificate Hospital or Attending Physician: this After nours after death.

nerai Director: A
filled in by the fu within 24 hours af

To the Funeral D

completely filled i

Baltimore, Maryland 21215-0036

Box 68760.

o

Records, P.

Division or Vital

Hospital Other: 3 DOA 1 ☐ Yes 2 ☑ No 1 Hnpatient 2 ER/Outpatient 4 \sum Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

29c. License number

D25886

29d. Date signed (Month, Day, Year)

200

Marc

MARYLAND 21204

State Registra

LILIA CEBALLOS. 31. Date filed (Month, Day, Year) MAR 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 5:20 AM SALVA MARCH 19 2007 /Medical HAIM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CENTER BALTIMORE
If Under 1 Year | If Under 24 Hrs JOHNS HOOKING BAYVIEW MEDICAL 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F 228-45-9993 Director June 25 1933 Israel Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Tiberias Directo Israel 10e. Street and Number 10f. Zip Code NIA 10g. Citizen of What Country? Israel 744/2 Yefe Nof St. by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Masouda Nechmad Jacob Balva 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 744/2 Yefe Nof St. Tiberias Israel Rina Balva 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 03-21-2007 Tiberias Israel Tiberias Cemetery 4 Donation 5 Other (Specify) 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Chapels 3803 14th Ave. Shomrei Hadas Brooklyn NY 11218
Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final FAILURE **Physician** RESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Acute Distress Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Chrossic Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ieral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached t 1 Yes 2 No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown apstru CANCER Be Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes performed 2 No 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AS414735 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 4940 Rollinone Maryland Eastern Avenue Christophen 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		,	For State Registrar	State o	f Maryla		artment <i>rtificate</i>			d Mental H	ygiene Reg. No	2007	08453
	Physici		1. Decedent's Name (First, Mic Jane France							2. Date of I	Da		3. Time of Death
	/Medi Examir		4a. Facility Name (If not institut	ion, give street and nur	nber)		4b. City, T	own, or Lo	ocation of De	March eath		2007 County of Death	9:45 A [™]
	71 60 m		Greater Balt				Tov	vson	I Indo 041	les la p	В	Baltimore	
	Funeral Director		5. Social Security Number 214–38–5294	6. Sex 1 ☐ M 2 💢 F	65	s. <i>l</i> as <i>t birth</i> da <i>y)</i> Yrs.			f Under 24 F Hours N	lin. 8. Date of E (Month, I July	Birth Day, <i>Year)</i> D. 7. 1. 0	9. Birth	place (State or Foreign intry) MD
	·		Usual Residence of Decedent								2/ 19	741	FID
	e Marylar a-f show iffied at	ctor	MD Balt	imore	10c. C	ity, Town or Lo Ti	moniur	n					10d. Inside City Limits Y☐ Yes 2 ☐ No
	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 210 Belmont Fo	rest Court	Uni	t 401	10f. Zip (ode 1093			10g. Cit USA	tizen of What Cou	intry?
1 %	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	y Funer	11. Marital Status 1 Never Married 2 Mi	If Yes, Giv	2∭No re		Was Decede If Yes, specil 1 ☐ Yes 2		anic Origin? Mexican, Pu Specify:	(Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Ameri Black, White Specify: whi	, etc.
MS	72 hours "natural", edical Exa	ed by	3 Widowed 4 Noivorce	ent's Education	ates:		dent's Usual				16h K	ind of Business/Ir	
A√ 1215	s 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical I	To Be Completed	(Specify only high	est grade completed)	-4or 5+)	(Give	kind of work DO NOT use estate	done duri retired)	ing most of	working		eal esta	•
D B	e filed al Hyg i other vent, i	3e C	17. Father's Name (First, Middl					18	B. Mother's N	Name (First, Middi	e, Maiden	Surname)	
<u>√</u> Z	ould b Ment marked	10	John George S							stine Ma:			
Mar	nd 2 sh Ith and 27 Is m		19a. Informant's Name/Relatio. Glen H. Brown							Rural Route Num			p Code) im, MD 21093
$R_0 N N$ more, Maryland	es 1 ar of Hea item 2	1	20a. Method of Disposition	<u> </u>	20b.	Place of Dispo			-	Date	·	ocation - City or T	
Z i	Page tment tant: It		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	^(Specify) entomb		oudon P	ark Ma	ausol	eum	19-07	1	imore, M	
E Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service	e Licensee	rt					aight Fu esville,			Chape1
	Physician		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition	or complications that cast only one cause on each	1 1	ath. Do not ent	er the mode		such as card		arrest,		Approximate Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	aDue to (or as a conse	quence of):	0						One year
	uted f ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (yr as a conse	quanta of):							
8760,	ate be executed thysician and the burial-transit	Ilcal Exa	resulting in death) Last	C. Due to (or as a conse	quence of):							
9	rtificate ng phy as the		IF FEMALE	- Qi		-							
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown		irth 2□Fet ant at time of	tal death 3 ☐	Ectopic pred Other (spec					23d. Date of deliv Month	rery Day Year
rds, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant condi	tions contributing to de	ath but not re	sulting in the u	nderlying cau	ise given i	n Part I.		2		the cause of death? bably 4
Division or Vital Records,	The law requate has been page 2 should	Completed									opsy formeg?	prior to co death?	opsy findings available ompletion of cause of
Vita	ding Physician: The Interpretation of After this certificate he funeral director, page	Be	25. Was case referred to medic examiner?	Hoopital:				Othory		Death (Check only			
0	Physer this eral dir	7. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	of Injury	ER/Outpatien 28b. Time of				Home 5 ☐ Res			fy)
noi	Attending r death. ector: After	ation	Z L Accident	ing (Monta tigation	h, Day Year)	Injury	М	c. Injury at Work? 1 ☐ Yes	2 □ No			y doddined	
Divis	tal or Atters as after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter	minod 20e. Place	of injury - At h ng, etc. <i>(Spe</i> c.	nome, farm, str ify)	eet, factory,	office		28f. Location City or To	(Street an own, State	nd Number or Run e)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Certify Certify	ing Physician: To the Il Examiner: On the ba and mann	asis of examin	owledge, death ation and/or in	occurred at vestigation, i	the time, n my opini	date and plate on, death o	ace, and due to the ccurred at the time	e cause(s) e, date and) and manner as s d place, and due t	stated. o the cause(s)
	Vointh vointh	M	29b. Signature and title of certif	el a. La	ine	, M.L).	D /	787	3	M	te signed (Month,	Day, Year)
1	1		30. Name and address of person Manshall A.	n who completed cause Levine 6	of death (Ite	m 23a) (Type, <i>New</i>	Print) +L, C	han	les s	treet	To	wson,	Mayland
	Sta Registr		31. Date filed (Month, Day, Yea MAR 1 9 20	907 September 32. Re	egistrar's Sign	ature for the)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 13^{pay} Wesley Sherman 2007 Bright 2:30am M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10542 Jason Lane Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 20, 1938 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ▼ M 2 □ F Months Days 217-34-2596 68 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hijury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 1√Yes 2□No Completed by Funeral Director Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10542 Jason Lane 21044 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Bright Estella Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Olivia M. Bright (Wife) 10542 Jason Lane Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 3-17-07 Bushy Park Ceemtery Cooksville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Scilling HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC NON-SMALL CELL LUNG CANCER Physician GMO /Medical Due to (or as a consequence of): Examiner FIBRILLATION ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit on the page 2 should be detached for use as the burial-transit Diabetes signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, PER Physician/Medical TENSION IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 3 3 3 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March, 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEA LAZARMO 6355 TEN DAILS Rd CLARKSVILLEMD 21029

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 52 **Z**00 /Medical Facility Name (If not institution, give street and 4c. Examiner mor Social Security Number last birthday) If Under 1 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2XF 214-38-0783 87 Yrs. Director 03/15/1919 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2307 West Lanvale Street 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by SpecifyAfrican American 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 domestic housewi fe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown ဥ unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Katina Barnes / Great-Granddaughter 2526 Loyola Southway; Baltimore, Maryland 21215 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or or 3 ☐Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 03/21/2007 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 NOrth Gilmor Street; BAltimore, Maryland هله 23a. Part1. Enter the disease, or com-shock, or heart failure. List only one d the death. Do not enter the mode of dying, such as cardiac or respiratory arres Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a conseq nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached t 2 DN 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No 1⊟ Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မှ 1 ☐ Yes 2 1 1 1 1 1/1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home this 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director; / 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) License number title of certific 29d. Date signed (Month, Day, Year) (Type, Print) 32 Registrar's Signature State Registra 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Irving Leonard Cook, Sr. March 14, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2023 Paulette Road Apt. 3 Dundalk Baltimore Co. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 → M 2 □ F Months Days Hours Min. Director 217-24-6251 23,1929 Aug. Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location Show r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or th and Mental Hygiene. 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must t 2023 Paulette Road Apt. 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2□No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3√ Widowed 4 Divorced Korean White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 Years Dredging Engineer Marine Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Griffith Earl Cook Charles Anna Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: if Item 27 is any injury or other trauonce. 1937 Orchard Point Road Pasadena, Maryland 21122 Mr. Lenny Cook (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 3/17/2007 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Chrone Obstructive dung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner mountine Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed type of dy Due to (or as a consequence of): du burial-tran Box 68760, attending physician for use as the buria Physician/Medical the ! IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a Ö 9□Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate Division or Vital 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 035763 STI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Ad 21224 Cordts an 5505 Hopkins Byurew Circle Grace A. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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07-01990 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		State of Maryland / Department of H 1- For State Registrar Certificate of D				17 0045
Physicia M∽dical Exami		Decedent's Name (First, Middle,Last)		2. Date of Death Month March 13,	Day Year	3. Time of Death 2131 hrs
		1-6- 11- 11- 11- 11- 11- 11- 11- 11- 11-	City, Town, or Location of Dea		4c. County of D	
Funeral Director		5. Social Security Number 216-31-3924 6. Sex 18 Yrs. 18 Security Number 18 18 Yrs.	If Under 1 Year If Under 24H	Irs. 8. Date of Birtl		Birthplace (State or reign Maryland
e Maryland or 28a-f show any Ned at once.	tor	Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	I Director		Of. Zip 210213	10	g. Citizen of What C USA	country?
r death or iter must	by Funeral	3 Widowed 4 Divorced If Yes, Give Year 1 Ye	ecedent of Hispanic Origin? (specify Cuban, Mexican, Puen s 2 No specify:	to Rican, etc.)	14. Race - An White, etc Specify.	
n 72	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A 15. Decedent's Learning most of during most of the secondary (0-12) N/A Studer		etired)	Patterson	,
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than matic event, the Medica	Be	Devon Hezekiah Clarke	Anita	ne (First, Middle, M. A. Grahan	n	
MD 2: nd 2 should thith and M m 27 is ma	7		dress. (Street and Number of AVE. B	Rural Route Numb altimore	er Mb orzawa s	ate, Zip Code)
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If iten 27 is marked other thinjury or other traumatic event, the Med		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Dongtion 8 Other Specify: 21. Signature of Funeral Service Licensee	yamenorial 3/2	2/2007	20c. Location - City Pimenium, M)
		Hofeto Kh. Parkv.	e and Address of Facility Fun ille 8800 Harford	eral Chapel Rd. Parkvi	L & Cremetic ille, MD 212	n Services 34
Physician /Medical Examiner		23a Pag(1. Enter the disease, or complications that caused the death. Do not enter the mailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				-
ted d ansit	Examiner	Cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
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5x 6876 ath certificate attending phy or use as the	sician/M	FFEMALE: 23b. Was decedent pregnant in the past 12 months?	eath 3 Ectopic pregn	ancy	23d Date of deliv Month	ery Day Year
i, P.O. B ires that the de signed by the	اھ	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.			to the cause of death?
of Vital Records, ag Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed			24a. Was an autopsy perform	prior to	
Vital Recysician: The his certificate director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	26. Place of Death (Check		esidence 6 Oth	ner:
ion of tending Pheath. or: After the funeral	⊢ †	27. Manner of Death 28a. Date of Injury 28b Time of Injury 1 Natural 5 Pending Mar 13, 2007 2022 hrs	28c. Injury at Work?	28d Describe ho Subject shot	w injury occurred	
Division pital or Attendir ours after death. erral Director: A filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street	ctory, office building, etc.	or Town, Sta		Rural Route Number, City more , MD
Division To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the 1	edical (29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred a very one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, and manner stated				
	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (M March 14, 2007	
6		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio, MD. Assistant Medical Examiner 111 Penn Stree	et, Baltimore, MD 2120	1		
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month March 15, DiMarino Sr.

4b. City, Town, or Location of Death /Medical Joseph 2007 2:30 P 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death 10 Lombardy Drive Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Yrs. Director 317-09-4297 88 Feb. 4,1919 Pennsylvania Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Baltimore Dundalk 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Lombardy Drive 21222 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Machinest Manufacturing marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fi f Health and Mental H tem 27 Is marked otl Be Salvatore DiMarino Marie Antoinette DiGiambatista ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Maxine DiMarino (Wife) 10 Lombardy Drive Dundalk, Maryland permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gdns. 3/19/2007 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Sign wre of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOKIA **Physician** /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) be executed burial-tra Due to (or as a consequence of): physician Physician/Medical law requires that the death certificate the ! as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy certificate 1□ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 | Yes 2 | Ne Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this nours after death.

neral Director: After this
filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

Box 68760, P.0. Division or Vital Records,

соmpletely

31. Date filed (Month, Day, State Registrar

29a. Certifier

29b. Signature and title

Medical

M.D

Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106

1 🚾 CertifyIng PhysicIan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D55306

Philadelphia Rd. Balt. MD 21237

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

and manner stated.

07-02068 Todd Denisuk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Todd Denisuk Madical Examiner March 16, 2007 1751 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Johns Hopkins Bayview Medical Center Baltimore **Baltimore County** 5. Social Security Number If Under 1 Year 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs, last birthday) If Under 24Hrs. **Funeral** Director Months Days Hours April 7,1962 217-82-4392 44 country) Maryland Usual Residence of Decedent any 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show Baltimore Eastwood Yes 2 X No Maryland with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7138 Eastbrook Avenue 21224 ö United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married 2 🗶 No Yes "natural", or after 3 Widowed Divorced f Yes, Give Year Yes 2 X No specify White Ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) 2 should be filed within 72 has and Mental Hygiene
27 is marked other than "m Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than or other traumatic event, the Medical Baltimore, MD 21215-0036 8 Years Steelworker Steel Industry 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Joan Marion Barth Daniel S. Denisuk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 7138 Eastbrook Avenue Baltimore, Maryland 21224 Margaret A. Denisuk 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date crematory or other place) 1 XBurial 2 Cremation 3 Removal from State permit. Page:
Department o 3/21/2007 Baltimore, Maryland Oak Lawn Cemetery Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician failure. List only one cause on each line. Retween Onset and /Medical Death Bronchopneumonia and fibrosis of lungs Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED attending physician or use as the burial AMEASED, 27, perME, g866, 4/2/07 The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown q Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy After this certificate has performed? death? ✓ Yes 2 1 🗸 Yes No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other 4 Hospital: 1 Inpatient 2 CER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: within 24 hours after deau.

To the Funeral Director: A 1 X Natural 1 Yes 2 No Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License numbei March 17, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

07-02015 Leona Durant

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Physicia cal Examin	n/	1. Decedent's Name (First, Middle, Last) Levra Durant	Mor	e of Death oth Dar och 15, 200	y Year 07	3. Time of Death 0756 hrs
(,)		4a. Facility Name (if not institution, give street and number) 4 N. Mount Street 4b. City, Town, or Loc Baltimore	cation of Death		4c. County of Death	
Funeral Director	4	216-28-6004 1 M 2 F 72 Yrs. Months Days		ate of Birth(M 4-26-	M/DD/YYYY) 9. Bir 1934 Foreig Co	
daryland 28a-f show any 1 at once.	ō	Usual Residence of Decedent 10a. State 10b. County N/A 10c. City, Town or Location Batternar	ر ف			10d. Inside City Limits 1 Ves 2 No
h the Maryl 3a or 28a-l otiffed at 9	I Director		223		Citizen of What Coul	ntry?
15-0036 filed within 72 hours after death with the Maryland I Hygiene. I other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes, specify Cuban, M 1 Yes 2 No 1 Yes 2 No second or Dates:	texican, Puerto Rican,		14. Race - Ameri White, etc.	Black,
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21215-0036 uid be filed within 7 Mental Hygiene. marked other than	Be	Robert Sawyer SR.	Mother Name (First,	ie J	tohnas	N
ore, MD 21 st. 1 and 2 should of Health and Me If item 27 is ma	To	19a. Informant's Name/Relationship (Type/Print) 19b. Mailing Address (Street at 1305 S, G-4) 20a. Method of Disposition 20b. Place of Disposition (Name of cement	Indon A	re B		nd, 2/223
Baltimore, MD 21215-00: pernit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Mass.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: I gnature of Funeral Service Licensee August M. Callese Tany M.	,			
Physician /Medical Examiner	1	23a. Fart I. Ent-yi the disease, or complications that caused the death. Do not enter the mode of dying, surfailure. Li vonly one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	ch as cardiac or respir	frences, s	aldenci shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b				
d sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
execulian and	/Medical E	d. UNPENDED AMENDED				
Box 68760, death certificate be the attending physic defor use as the bur	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Ectopic pregnancy		23d. Date of deliver	y Day Year
irs that the d signed by the	2			_		the cause of death?
ords v request should should	Completed		1[4a. Was an autopsy performed Yes 2 🗸	prior to death?	stopsy findings available completion of cause of es 2 No
Vital Recc sysician: The lan this certificate ha	To Be (25. Was case referred to medical 26.Place of	Death (Check only on her 4 Nursing Home	The same	idence 6 ✓ Other	r: Scene
Division of ' pital or Attending Ph ours after death. reral Director: After t		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury a 1 Yes	at Work? 28d. D	escribe how	injury occurred	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office build (Specify)	or	Town, State		iral Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date one) 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, de and manner stated. 29b. Signature and title of certifier 29c. License n	eath occurred at the tir	me, date and		e cause(s)
9 0	2	Theodor U. Vig JR. ms. O.C.M.			larch 16, 2007	na, bay, roar)
2			et, Baltimore, MD	21201		
Sta Regist		B/1/1/1 5 / 1111/ 2/12 - 27 // A/A				

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			1 - For State Registrar	State	of Maryla		artment of F rtificate of				ene No2 ()	07	08462		
	Physici	/sician FDNA I DOVI F									2. Date of Death Marth Pay 2, 2007 01:45FM				
	/Medio		4a. Facility Name (If not institution Saint Jose	nter	4b. City, Town, o						imore				
**************************************	Funeral Director		5. Social Security Number 216-24-0254	6. Sex 1 □ M 2 □ X F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. I	Date of Birth Month, Day, Y	1928	9. Birthpla Count Mary	ace (State or Foreign		
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	cation					10	d. Inside City Limits		
	a-f sh	ctor	MD :	Baltimor	e	Par	kville						1 ☐ Yes 2XINo		
	or 28 be not	Director	10e. Street and Number		<u> </u>		10f. Zip Code			10g	. Citizen of V	Vhat Count	ry?		
	eath v	Funeral	9603 Oak St		edent Ever in	118 121		234	ning (Cassifi	Van ar Na	US		n Indian		
036	should be filed within 72 hours after death with the Maryland nd Mental Hygene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, the Medical Examiner must be notified at	b	1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	ried Armed F	orces? 2 X] No ive		Was Decedent of H f Yes, specify Cub I ☐ Yes 2 【XNo		Blac	14. Race - American Indian, Black, White, etc. Specify: White					
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Maryland 21215-0036	within jiene.	Completed	Elementary/Secondary (0-12)	College ((1-4or 5+)	l .	OO NOT use retired USEWife	d)			At Ho	ome			
nd	e = 0 ≥	Be C	17. Father's Name (First, Middle,					18. Mothe	er's Name (Firs	st, Middle, Mai	iden Surnam	ne)			
yla	i Ment i Ment narkec	To	John D. Hi							Ebber					
Ξ	es 1 and 2 should E of Health and Ment Item 27 is marked r other traumatic e	V i	19a. Informant's Name/Relations John Doyle-				g Address <i>(Street</i> dbridge					State, Zip (Code)		
Baltimore,	jes 1 a of Hei of Item or othe		20a. Method of Disposition 1 Burial 2 Cremation		20b.	Place of Dispos	sition (Name of natory or other place	ce)	Date		c. Location -	City or Tow	vn, State		
Ē	t. Pag rtment rtant:		4 □ Donation 🕏 □ Other (S	Specify)	E.V.	ANS FUNER	AL CHAPEL A ERVICES PET Name and Addre	AND S	3-16-		nest Hi				
g	permit. Pages of Department of Hamportant: If Ite any Injury or ot once.		21. Signature of Funeral Service	Licensee L	dol-	E	Name and Addre ANS FUN OUT OF THE STATE OF T	VERAL	CHAP	Pill 1	800 H	arfo	rd Road ,MD 21234		
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5	ng Phy fter thi neral o	ii.	27. Manner of Death 1 Natural 5 □ Pendin	28a. Date		28b. Time of Injury	28c. Injury Work			Describe how i					
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	with Com.	2	29b. Signature and title of certified	aL-Lu	withie	en		number 1826			Date signed $3-\iota z$				
	10		30. Name and address of person				,	ng may process	I I law over two	1 177 275 1	halos ms -	1 /3 - 1 ***	ال المحر المحر الله المحر		
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07-01895

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Terry Lee Ermer State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Rea. No Physician/ Date of Death Month Medical Examiner Ermer Terry L. 1150 hrs March 10, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3146 Wallford Drive Apartment 2C Dundalk **Baltimore County** 5. Social Security Number 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY) Months Days Director Hours 217-62-4286 1955 Country) Maryland 1 X M 2 F 51 July 8, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 Yes 2 X No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic veent, the Medical Examiner must be notified at once. Dundalk Director Maryland Baltimore s 23a or 28a-f e notified at o 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 3146 Wallford Drive Apt. C uneral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married White, etc. 1 X Yes 屲 3 Widowed 4 X Divorced If Yes, Give Year Yes 2 X No specify: Specify: White ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Engineering Stationary Engineer 12 Years 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Dorothy Kenneth Ermer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. David Ermer 1438 Bonnett Lane Laurel, Maryland (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 3/14/2007 Hilltop Service Corp Towson, Maryland Donation 5 Other Specify: 21. Signatury of Funeral Service Licensee 2 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Maryland 21222 **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Cirrhosis of liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - tran Physician/Medical X UNPENDED AMENDED, 27, perME, g866, 4/12/07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown death Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed After this certificate has been s 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 N 1 🗸 Yes No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Inpatient DOA 2 ER/Outpatient 3 Nursing Home 5 1 V Yes 2 No Residence 6 V Other: Scene 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural t hours after death.
uneral Director:

y filled in by the fu 5 Pending 1 Yes 2 No 2 _ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours a To the Funeral I determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 11, 2007 Manel 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) MAR 1 9 State

Registra

07-01926 Barbara A Eder		1- For State		in Black Indel and / Departm Certific		Health ar			е	20	1 5	001. C		
Physici	an/	1. Decedent's Name (First, Midd	lle,Last)				_		Reg. Nof Death			3. Time of Death		
Medical Exami	ner	-aradra inni bo							h 11, 20	07		1735 hrs		
		4a. Facility Name (if not institution Good Samaritan Hos				. City, Town, c			n/a					
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r death w or items	/ Funeral		larried Armed F 1 Yes Yorced If Yes, Give Ye	2 X No	If Yes		ın, Mexican,	in? (Specify Yes Puerto Rican, e		14. Race White	etc.	an Indian, Black,		
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner.	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)		ide completed) 16a. 1-4 or 5+)		Usual Occupa t of working life		ind of work done use retired)	161	iness/In	dustry			
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Z 5 5 5 5		Mrs. Denise B. Kohlhepp (Sister) 9108 Summer Park Drive Baltimon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Local										21234 own, State		
Baltimore, ME permit Pages I and 2 s Department of Health an Important: If item 27 injury or other traum		1 Burial 2 Cremation 3 Removal from State F.Vans Funeral Chanel March 14,										l,Maryland		
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exa	and manner	of examination and/or stated.	investigation			urred at the time						
	Σ	29b Signature and title of certified	er			29c, Licens	M.E.			d. Date signer arch 12, 2		h, Day, Year)		
		30. Name and address of person	who completed cau	se of death (Item 23a)		0.0.			101	ai Gii 12, 2				
		Pamela E. Southall. M			r 111	Penn Stree	et. Baltimo	ore. MD 212	01					

State 31. Date filed (Month, Day, Year)
Registrar MAD 4 2

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32. Palistrar's Signature
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			For State Registrar	State of Ma	ryland		artment of lertificate of			giene	7	08465		
	Physici	an	1. Decedent's Name (First, Middle, Lass Alvin R. Flesher)					2. Date of De	Day	Year	3. Time of Death		
	/Medio	al	4a. Facility Name (If not institution, give	street and number)	- 11-		0 1	or Location of D		4c. County	OD + of Death	1110		
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	h with t	ai Dir	1821 Dunwoody Road	l			21234			USA	***************************************			
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow I.a Mudical Exam ar must he rotified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13	Was Decedent of If Yes, specify Cul					American Indian, White, etc. White		
21215-0036	n 72 ho natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)		(Giv	edent's Usual Occu e kind of work done DO NOT use retin	during most of	working	16b. Kind of Bu	isiness/ir	ndustry		
212	d withir giene. or than	omo	Elementary/Secondary (0-12)	College (1-4or 54	+)	Engi				Mechani	cal	Engineering		
	ntal Hy ad othe	To Be (17. Father's Name (First, Middle, Last) Stephen A. Flesher						_{Name (First, Middle} Petrisko	e, <i>Maiden Sum</i> ame)				
Maryland	should ind Mei i mark umatic	Ļ	19a. Informant's Name/Relationship (7			19b. Mai	ling Address (Stree	, ,	Rural Route Numb	er, City or Town,	State, Zi	ip Code)		
	and 2 lealth a m 27 ls		Joanne H. Flesher	/ wife			Dunwoody	Road;	Parkville Date	, MD 212		Town State		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28e-f ehow any Injury or other traumatic event, the Wadical Examinat must be notified at ance.		20a. Method of Disposition 1 □ Burial 2 M Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Furer I Sarvice Land)	Hill1	top S	ematory or other place Co Service Co 22. Name and Addi	orp. 3/	17/07	Towson,	MD York	c Road		
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]	# Hospital 24 hours a Funeral i etely filled	dical Ce	29a. Certifier 12 Certifying Ph	ysician: To the best of liner: On the basis of and manner stat	examination	edge, de	ath occurred at the investigation, in my	time, date and p opinion, death o	i?Zi Dui lace, and due to the occurred at the time,	cause(s) and madate and place,	nner as and due	stated. 212:		
	To the within To the comple	Me	29b. Signature and title of certifier **Thirdum 7.8	·				2885	5	29d. Date signe	1			

State Registrar

12+1

DHMH 17 Rev 1/2001

2435 W. Belvedere Ave.; Baltimore, MD 21215

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rhonda Fishel M.D. 2435 W. Belveder

31. Date filed (Month, Day, Year)

MAR 1 9 2007

			1 - For State Registrar	State of N		/ Depa		of H	ealth and	•		20	e. 07	0846		
	Physic /Medi Exami	cal	1. Decedent's Name (First, Mid RAYMON D 4a. Facility Name (If not institut		-)	GI	ESE 4b. City. I	own or	Location of Dea	2. Date of D Month March	eath Da	y Y	ear 2007	3. Time of Death		
	Funeral Director	ler	5. Social Security Number	BAYVIEW MEA			BACT	mo		8. Date of B	rth ay, Year)	N	/A	ce (State or Foreign) and		
	death with the Maryland ms 23a or 28a-f show r must be notified at	Director	Usual Residence of Decedent 10a. State 10b. Coun Maryland Ba 10e. Street and Number	ltímore	10c. City,	Town or Lo			Du	ndalk				. Inside City Limits 1 □Yes 2 No		
	ns 23a or must be n	al Dir	7833 Scholar	Road			10f. Zip (222			izen of Wha ited	-			
920	72 hours after deat "natural", or Items 2 edical Examiner mu	by Funeral	11. Marital Status 1 □ Never Married 癸ৢৢৢৢ M 3 □ Widowed 4 □ Divorce	12. Was Deceder Armed Forces 1 XYes 27 If Yes Give	? No www.t.t.		Was Decede f Yes, speci	ent of His fy Cubar		Specify Yes or N rto Rican, etc.)		14. Race -	American White, etc	Indian,		
Maryland 21215-0036	d within 72 ho giene. r than "natur the Medical	Completed	(Specify only high Elementary/Secondary (0-12	ent's Education hest grade completed)) College (1-4or		(Give life. L		done di retired)	uring most of wo	orking		ind of Busir	ness/Indus			
d 2	Hyg It	Be Co	12 Years 17. Father's Name (First, Middi	le, Last)		T.V.	Techr			me (First, Middle		elevi Surname)	sion			
ylan	Ω ⊕ □ □	To B	Emil Giese						Lillia	n Steige	rwal	d				
	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relatio				g Address (Schol			ural Route Numi indalk,			-	*		
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item 3 any injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State (Specify)	cen	netery, cren	sition (Name natory or oth	er place		Date 3/16/20		ocation - Cit Dunda	-	, State Maryland		
Balt			22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 2122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between													
ì	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	-a. Pula	d the death. ine.	Do not ente	er the mode	of dying	, such as cardia	c or respiratory a	arrest,		A In O	pproximate terval Between nset and Death		
1760	te be executed wysician and be burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Small Bowe Obstruction									2 weeks I month				
P.O. Box 68	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi										23d. Date of delivery Month Day Year				
	quires that in signed b uld be deta	þ	Part II. Other significant condi	itions contributing to death	out not resultin	ng in the un	derlying cau	se giver	in Part I.			ise contribu ⊒ No 3[cause of death?		
Division or Vital Records,	The la	Completed								24a. Was auto perfo 1∐ Yes		prio dea	r to compl th?	findings available etion of cause of		
Κ	Physician: r this certifice ral director, p	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat	ent 2 🗆 ED	l/Outpatient	3 □ DOA	Other		ath (Check only						
ion or	nding Phys th. : After this e funeral di		27. Manner of Death 1 Natural 5 □ Pend	28a. Date of Inj	ury 28	Bb. Time of Injury		. Injury a Work? 1 □ Ye		dome 5 ☐ Resi 28d. Describe			Specify)			
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could	mined 28e. Place of In	jury - At home tc. <i>(Specify)</i>	e, farm, stre	et, factory,	office		28f. Location (City or To	Street an wn, State	d Number o	r Rural R	oute Number,		
	he Hospit in 24 hour he Funer: pletely filk	Medical (29a. Certifier 1 Certify (Check only one)	ring Physician: To the best al Examiner: On the basis and manner s	of examination	edge, death n and/or inv	occurred at estigation, i	the time	e, date and plac nion, death occ	e, and due to the urred at the time	cause(s) date and	and manne I place, and	er as state due to th	d. e cause(s)		
	To t To t	Σ	29b. Signature and title of certif	ier Lawry	10 (10.			icense i			29d. Dat	e signed (N	fonth, Day	/, Year)		
	44	-	30. Name and address of perso			a) (Type, F		-25	000		Mar	ch	13,2	007		
12.	Sta		JACQUELLUE G 31. Date filed (Month, Day, Yea	ARONUK WAN). 40		EAST	ERN A	JENUE	B	MITH	ORE	MO 21224		
	Registr		MAR	1 9 2007	Euro 1	de de	park	0								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

50.00			For State Registrar		State	of Mary		artment of F ertificate of t		лептат ну	Reg. No.	O 12 mg	08467	
影 69	1. Decedent's Name (First, Middle, Last)									2. Date of De Month	eath Day	y Year	3. Time of Death	
4)4	Physici /Medic		Bettie R Gomez			March	13	2007	8:04 ^{P M}					
	Examir	do un	4a. Facility Name (If πot in	institution, give	street and nu	mber)		4b. City, Town, or	Location of Death		4c.	County of Dear	th	
			Laurel Regiona	al Hospi	tal			Laure1			Pr	ince Geor	rges	
, 15	Funeral		5. Social Security Number	er 6. S	ex	7. Age (In	yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birl	thplace (State or Foreign	
15.2	Director		100-32-3043	1	□M 2∏F		63 Yrs.	Months Days	Hours Min.	July 21	1943		ountry) York	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at		Usual Residence of Dece 10a. State 10b.	edent . County		10	c. City, Town or L	ocation					10d, Inside City Limits	
	Many f sh	힏	Maryland Pr	rince Geo	orges		aurel						1 Mary Yes 2 No	
	n 72 hours after death with the Marylar "natural", or items 23a or 28a-f show adical Examiner must be notified at	Director	10e. Street and Number		J. 900			10f. Zip Code			10g. Citi	izen of What Co	ountry?	
	with Ba or t be		504 11 1 6 1											
	eath	era	501 Main St Ap	pt 205	12. Was Dec	edent Eve	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No	USA_	14. Race - Ame	erican Indian,	
	iten iten ner	Funeral	1 Never Married	2□ Married	Armed F	orces?			ın, Mexican, Puèrto	Rican, etc.)		Black, Whit	•	
36	rs af r', or cami	b	3 ☐ Widowed 4 🗖 [If Yes, G Year or D	2X No ve ates:		1 ☐ Yes 2Ã No	Specify:			Specify: Bla	ck	
21215-0036	hou ttra al E	Pg I		Decedent's Ed			16a. Dece	edent's Usual Occup	ation		16b. Ki	ind of Business	/Industry	
5	be filed within 72 hours list Hygiene. dother than "natuevent, the Medical	Completed	(Specify on	nly highest gra	de completed)		(Give	e kind of work done o DO NOT use retired	during most of work f)	ing	ĺ		•	
12	within iene. than " the Med	Ĕ	Elementary/Secondary 12	y (0-12)	College (1-4or 5+)	Toloni	none Operato			Retai	1		
	e filed al Hygi other vent, tl		17. Father's Name (First,	Middle Last)			Telebi	ione operato	18. Mother's Nam	e (First, Middle				
an C		Be	,	, madro, zwor,						,	,	,		
Maryland	d 2 should be and Ments 7 is marked traumatic even	은	Larkin Goudy,	D-1-4	D-i		40h M-11	: Add (C44	Viedell Nor		an City o	Town Clate	Zin Code)	
Jai	3 S S		19a. Informant's Name/F	, ,			19b. Maii	ing Address (Street	and Number or Hui	rai Houte Numi	er, Gily d	or rown, State, I	zip Code)	
	E = 0 =		Renee Goudy /					Pineywoods P		MD 2072 Date		cation City or	Taura State	
O.	SEE		20a. Method of Disposition 1		Removal from	State	cemetery, cre	osition (Name of ematory or other plac	e)	Date	20c. Lc	ocation - City or	Town, State	
altimore,	Pages ment of I ant: If ite ury or o		4 □ Donation 5 □				Cate Of Hea		3/21/2			r Spring,	, MD	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature Funeral	l Service Licen 仏	Wells	,		22. Name and Addre 7601 Sandy S						
,	W Water	4	23a. Part1. Enter the dis shock, or heart faile	sease, or comp	olications that	caused the	death. Do not er	nter the mode of dyir	g, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between	
	Dhunisian		Immediate Cause (Final										Onset and Death	
	Physician /Medical		disease or condition resulting in death)	-	a		ne Fractu	re				_		
	Examiner		Due to (or as a consequence of): b. Ventricular Tachycardia 8										8 hours	
		70	Sequentially list condition	ns,	b. Ventri	cular for as a co	lachycard	а					o nours	
T	ted Isit	Ē	cause. Enter Underlying Cause (Disease or injury	1									8 hours	
,	and and II-trai	Examiner	that initiated events resulting in death) Last		c	(or as a co	insequence of):						0 11001 5	
09	be executed sician and burial-transit	ᄪ												
68760,	ficate be executed physician and is the burial-transit	edical			_d									
		/Me	IF FEMALE:		23c. If yes, ou	tcome of n	regnancy					23d. Date of de	livon	
Box	death cert e attending d for use a	ian	23b. Was decedent preg in the past 12 mont		1 Live	birth 2	Fetal death 3	☐Ectopic pregnancy	,			Month	delivery Day Year	
o	0 0 0	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4⊟Preg 9□Unkr	nant at tim lown	e or uearri 5	Other (specify)						
<u>Ч</u>	d by etacl	F.	Part II. Other significant	t conditions o	ontributing to a	laath hut n	at reculting in the	inderlying cause div	an in Dart I	23e Did	tohacco i	use contribute to	the cause of death?	
m.	The law requires that the te has been signed by the bage 2 should be detache	þ		t conditions c	ontributing to c	leath but in	or resulting in the	andenying cause giv	on iiir ait i.		Yes 2		robably 4 🛣 Unknown	
Sic	equir	be le	Diabetes								165 2		TODADIY 47 OTIKTOWIT	
or Vital Records	law re as be 2 sho	Completed	Coronary Arte	ery Disea	ise					24a. Was			e autopsy findings available to completion of cause of	
Œ	The lav	E									ormed? 2 💢 No	death?	•	
ta	i lcian: Th certificate ector, pag	Be C	25. Was case referred to	o medical					26. Place of Deat					
>	Physician: this certificanal director,	To B	examiner? 1 X Yes 2 No	Ĭ	Hospital: 1 💢	Inpatient	2 ☐ ER/Outpatie	ent 3 DOA Oth	er: 4 🗆 Nursina Ho	ome 5□Res	idence	6 ☐Other (Spe	ecify)	
ō	a Ph		27. Manner of Death		28a. Date	of Injury	28b. Time	of 28c. Injur		28d. Describe				
o	nding I th. : After : funer	후	1 ☐ Natural 5 [2 🔀 Accident	Pending investigation		nth, Day Ye 13 , 20		l l		Driving h	er ca	r and los	st control	
S	Attending r death. ector: After by the funer	ica	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place	e of injury	At home, farm, s	treet, factory, office		28f. Location	Street an	nd Number or Ri	ural Route Number,	
Division	after after Dire	Certification:	4 ☐ Homicide	determined		ling, etc. (5	Specify)			City or To		e) streets, l	aurel MD	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Directors completely filled in by the		29a, Certifier 1	Certifving Ph	stree vsician: To th	e best of m	y knowledge, dea	th occurred at the tir	ne, date and place.	and due to the	cause(s)) and manner as	s stated.	
	Hos 24 ho Fun stely	lica	(Check only 2 one)	Medical Exam	niner: On the I	pasis of exa	amination and/or i	nvestigation, in my	ppinion, death occu	red at the time	, date and	d place, and du	e to the cause(s)	
	the ithin of the other	Medical	29b. Signature and title of	of certifier			13	29c. Licens	e number	730	29d. Da	te signed (Mont	th, Day, Year)	
	L≥	-	MOA	Allan	Criti	SICI	9re /			7	MA	RcH, 1	3,2007	
,			1 10000	will	Pag	1101	an	DU	06056	2	- ·, ·	A D	•	
	20		30. Name and address of	erson who	completed cau	se of death	(Item 28a) (Type	, Print) Mo	JAMM (D A	-A7	1 /+/		
	0		7300 VA	NDUS	EN K	DAD	LAU	REL ,	MARYL	AND	20	707		
	Sta		30. Name and address of AVREL A 300 VA	ay, year)	2007	negistrar's	Signature	docules.						
	Registi	ar	ţi.	E I NHM	LU4/	Fred Little	Coprise Coppedie	the state of the s						

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			1 - For State Registrar	State of Ma	ryland /	Depa		of H	ealth a		ntal Hygi	ene g. No.2 0 0		00458	
	Physici	an	Decedent's Name (First, Middle, Last) Betty Jean Hawl							2	Date of Death Month	Day Y	ear	3. Time of Death	
	/Medic	al					Ab Ciby T	OUE OF	L ocation o		arch l	13 2007 11:10a			
	Examin	er	4a. Facility Name (If not institution, give a Continuum Care At						Death		4c. County of Death Carroll				
	Funeral Director		5. Social Security Number 6. Security Number 15. Security Number 1		(In yrs. last b	irthday) Yrs.	If Under 1	Year		Min.		Year) 9	Birthp Coun	lace (State or Foreign try)	
	nyland show	<u>.</u>	Usual Residence of Decedent 10a. State 10b. County MD Carrol1										1	0d. Inside City Limits 1 1 Ves 2 □ No	
	he Ma	ecto	10e. Street and Number		- Dyrk			ode.			10	g. Citizen of Wh	at Cour	71	
	3a or 3	10	521 Manor Road				,		,			USA		,.	
36	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other then "naturel", or Items 23e or 28e-f ehow event, the Medical Examinat must be notified at	by Funeral Director	1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ XN If Yes, Give	Sykesville Sykesville Sykesville Sykesville Sykesville Sykesville Sykesville				14. Race - Black, Specify:	Americ White, Whi	etc.				
8	ture!	ed b	3 Nidowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	168	a. Deced	lent's Usual	Occupa	ition		1	6b. Kind of Busi			
21215	s within 72 piene. r then "ne tte Medic	Completed	(Specify only highest grad		+)	life. L	DO NOT use	k done d e retired)	uring most	t of working		health o	care	2	
Baltimore, Maryland 21215-0036	uld be filed Aental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Martin Lantz							,					
Mary	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "naturel; or Iteme 23a or 28a-f ehow amply injury or other traumatic event, the Madical Examinat must be notified at any injury or other traumatic event, the Madical Examinat must be notified at ance.	ľ	19a. Informant's Name/Relationship (Ty Robert Reinhardt J												
ore,			20a. Method of Disposition 1 🖺 Burial 2 🗆 Cremation 3 🗆 F	Removal from State	1				. !_			0c. Location - Ci			
3altim	permit. Pa Depertmen Importent: eny injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens → Yugu Jacquet		Lake	22	. Name and	Addres	s of Facility	y Haig	ht Fune				
	405.4	L	23a. Part1. Enter the disease, or compl	ications that caused	the death. Do									Approximate Interval Between	
	Physician /Medical Examiner price of the physician of th	Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if amy leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Cause (Disease or injury that initiated events C.										Onset and Death		
x 68760,	0 0	cal	d												
P.O. Box	The law requires that the death certificat the has been signed by the ettending phy tage 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome to pregnant at 1 ☐ ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (special form)										23d. Date of delivery Month Day Year		
rds, P	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions co	ntributing to death bu	at not resulting	in the u	nderlying ca	iuse give	en in Part I.					ne cause of death?	
Division of Vital Records,		Completed									autopsy	pri led? de	or to co ath?	psy findings available mpletion of cause of 2 No	
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	aOEB#)t==ti==		Othe	200				(Co not		
on of	Attending Physic death. •ctor: After this by the funeral di	tlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b	. Time of	28	Bc. Injury Work	at c?	28				y)	
Divisi	after deal after deal Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined			farm, str	eet, factory,	, office		28			or Rura	I Route Number,	
	To the Hospital or Attending PP within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C		rsician. To the best to iner: On the basis of and manner sta	examination a										
)	vithir To th comp	Me	29b. Signature and title of certifier				29c.		number	25		3 191	Month,	Day, Year)	
l			30. Name and address of person who co	ompleted cause of do	eath (Item 23a	(Type,	Print) (Re)	vd	n	1216	minis	r 2	115	7	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1034	2								

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amend item 29d per doc 9865 3-19-07 vt.
State of Maryland P Department of Health and Mental Hygiene

		•	For State Registrar	State Orivialyla		rtificate of I			Reg. No 2 0 0	7 08469
	Physici	an	1. Decedent's Name (First, Middle, Las					Date of Dea Month	ath Day Yea	
	/Medic	al	47 11 12 12 13	Ruth M.	Hoe	tner 4b. City, Town, or	. Location of Do	March	7, 2007 4c. County of De	4:35 P M
" کیر	Examin	er	4a. Facility Name (If not institution, give					eain	4c. County of De	Baltimore
	Funeral		Genesis Heritage 5. Social Security Number 6. Se	Meridian Ctr. ex 7. Age (In yr	s. last birthday,	If Under 1 Year			h 9. E	Battimote Birthplace (State or Foreign Country)
-	Director		217-40-3051 Usual Residence of Decedent	□M 21xF 68	Yrs.	Months Days	Hours M	in. (Month, Day July 2		aryland
	yland now at		10a. State 10b. County	10c. C	City, Town or L				•	10d. Inside City Limits
	e Mar ia-f sl	cto	Maryland	N/A		Balt	imore C			1 ∑X es 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director	10e. Street and Number 6721 Fait Avenu	e		10f. Zip Code 2122	4		10g. Citizen of What United St	
	r dea	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	. 14. Race - Ai Black, W	merican Indian, hite, etc.
21215-0036	ours afte ral", or if Examin	हि	X□ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	, ,		Specify:	White
5-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usual Occup e kind of work done o DO NOT use retired	ation during most of v	vorking	16b. Kind of Busine	ss/Industry
121	within ene. than he Me	duc	Elementary/Secondary (0-12)	College (1-4or 5+)					Restaura	nt
d 2	filed Hygi other ent, tl		8 Years 17. Father's Name (First, Middle, Last)		KIL	chen Work		lame (First, Middle,		iiic
lan	Ald be fental rked of tic ev	To Be	Christian C.	Hoerner, Sr.				Emma Gr	ob	
Maryland	and N and N Is ma		19a. Informant's Name/Relationship (Type. Print)					er, City or Town, State	
Z	and and m 27		Mr. Ricky Citran			7 White A	venue		, Maryland	
Baltimore,	it of H		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	osition (Name of ematory or other place	i	Date	20c. Location - City	
ţi.	it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify 21. Signatur Funeral Service Licer			t. of Jes 2. Name and Addre		3/10/200	7 Dunda.	lk, Maryland
Bal	Depar Impor any fr		Maryon C	E land	D	uda-Ruck	Funeral	indalk. Ma	Dundalk, aryland 21	Inc. 222
	7557		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	ath. Do not en	ter the mode of dyir	ng, such as card	liac or respiratory ar	rrest,	Approximate Interval Between
	Physician		Immediate Cause Final disease or condition	ATRIAL	- 11		LATI			Onset and Death
7	/Medical Examiner	Н	resulting in death)	Due to (or as a conse	equence of):	1 A		ui DEN		
	The Fift	<u>.</u>	Sequentially list conditions,	b. Due to (or as a conse	equence of):	SULLA	K F	u wx		-
T	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	HYPER	FEN	SIM				
v.	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Lie to (or as a cons	equence of):					
68760,	ate be nysicia he bu	Medical		d. DEPRES	S10H					
	ertifica ing ph e as tl		IF FEMALE:							
.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify) _	<i>y</i>		23d. Date of Month	delivery Day Year
Д	that ned by deta		Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
rds	quires en sign uld be	ed by						1 0	Yes 2□No 3□	Probably 4 Dinknown
Records,	slcian: The law requires certificate has been sign rector, page 2 should be	Completed						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
Ä	The I	mo						perfo	rmed? death	1?
or Vital	sian: ertifica ctor,	Be	25. Was case referred to medical examiner?					Peath (Check only o	ne)	
7	Physician: this certific ral director,	2	1 Yes 2 No		ER/Outpatie		4 Nursin		dence 6 Other (S	pecify)
n C	Jing F	io ::	27. Manner Teath 1 Latural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wor	ryat ′k? Yes 2∐No	28d. Describe r	now injury occurred	
Division	Attending r death. ector: After by the fune	licat	3 Suicide 6 Could not be	e 28e. Place of injury - At	home, farm, si		100 2	28f. Location (5	Street and Number or	Rural Route Number,
Ο̈́	al or / s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)			City or Tox	vn, State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (nysician: To the best of my k miner: On the basis of exami and manner stated.						
	To th Withir To th comp	Me	29b. Signature and title of certifier	11 11.10	110	29c. Licens	2718	8	29d. Date signed (M	onth, Day, Year)
	(1)		30. Name and address of person who	completed cause of death (It	em 23a) (Type	, Print)	Dlace.	Olla	dall M	D 2/222
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature		, ~ ~	- cuit	- w 1.	
	Regist	rar	MAD 1 9 20	no Harres	1. 19	20/25				

			1 - For State Registrar	State of	Marylar		artment o			ental Hy	giene 007	08470
	Dharia	J. 18	1. Decedent's Name (First, Middl	e, Last)						2. Date of Dea Month	ath Day Year	3. Time of Death
*	Physici /Medic		E	dna		Hollin	gshead			March		10:04 A M
100	Examir		4a. Facility Name (If not institution	n, give street and num	ber)		4b. City, Tow	n, or Locati	ion of Death		4c. County of De	ath
*			Johns Hopkins	Bayview M	edical	Ctr.			city		N/A	
	Funeral		5. Social Security Number		. Age (In yrs.		If Under 1 You Months Da			8. Date of Birt (Month, Da		rthplace (State or Foreign Country)
-45	Director		215-12-3194	1□M 2√2F	86	Yrs.				May 8,		yland
	pg &		Usual Residence of Decedent 10a, State 10b, County		10c Cit	ty, Town or Lo	cation					10d. Inside City Limits
	anyia ehov	_	Toa. State		100.01	ty, TOWITOI LC	Gation					1 Yes 2X No
	8a-f	octo		altimore				Dunda	lk			
	vith ti	Director	10e. Street and Number				10f. Zip Cod				10g. Citizen of What 0	
	ath v	Funeral	7624 Old Bat					1222	0.11.0.10		United St	
	er de	nne	11. Marital Status	12. Was Deced	ces?	l.S. 13.	Was Decedent f Yes, specify (of Hispanic Cuban, Mex	: Origin? (Spe cican, Puerto F	cify Yes or No- Rican, etc.)	- 14. Race - An Black, Wh	
36	s aft	by F	1 ☐ Never Married 2 ☐ Mari	ied 1 □ Yes 3 If Yes, Give Year or Da)		1 🗌 Yes 2 🛣	No Spec	cify:		Specify:	****
21215-0036	within 72 hours atter death with the Maryland ene. then "natural", or items 23e or 28e-f ehow he M. digel Exemitive chart be multied at	Pe		t's Education	105.	16a Doco	dent's Usual Oc	coupation			16b. Kind of Busines	White
<u>.</u>	n 72	Completed	(Specify only highe	st grade completed)		(Give	kind of work do	one durina r	most of working	ng	TOD. KING OF BUSINES	windustry
7	with ene.	щ	Elementary/Secondary (0-12)	College (1-	4or 5+)		omemake	,			Oran II	
0	Hygi Hygi ther ant,	ပို	11 Years 17. Father's Name (First, Middle,	Last)		Π.	эшешаке		lother's Name	(First, Middle.	Own Ho Maiden Surname)	nie
an	d be antal) Be	James Thomp								eth Cannon	
Maryland	12 should be tiled within h and Mental Hygiene. 7 is marked other than "traumatic event, the Max	욘	19a. Informant's Name/Relations		(Son)	19h Mailir	n Address (Str	reet and Nu			er, City or Town, State,	Zin Code)
<u>8</u>	d 2 s th an 7 in trau		Mr. James E. H		(,		-					21219
	1 an Heal em 2 ther		20a. Method of Disposition	OTITINGSHEA			sition (Name o			ate	20c. Location - City of	
٥	it of or o		1 ⊠Burial 2 ☐ Cremation		tate	cemetery, crer	natory or other	place)			·	
≛	tent tent tent		4 Donation 5 Other (S		Ho		11 Mem.			/2007	Middle R	ver, MD
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examinar must be natified at ODEs.		21. Signature of Funeral Service	Licensee		D.	Name and Aduda - Ruc 222 Wise	k Fun	eral H	ome of	Dundalk, I aryland 21	Inc. 222
÷	-		23a Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the deat							Approximate Interval Between
	Physician		Immediate Cause (Final	Only one cause on ea	PIAL	C11	3R111	AT,	7 X/			Onset and Death
je.	/Medical		disease or condition resulting in death)	a. Due to (c	ras a consec	ruence of):	BRILL Y F.	*///	<i>O /</i> *			
Н	Examiner			RES	PIRA	TOR	x F	All	1/2F			
÷.		er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	r as a conseq	juence of):		// 2	-/ -			
	betr I Insit	듄	Cause (Disease or injury	DIA	BETH	=5						
	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (c	r as a conseq	uence of):						
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687	phy:			d. 2 C/1								
×	Physicien: The law requires that the death certiticate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outc	ome of pregna	ancy					23d. Date of d	alivan
Вох	atter tor s	clar	23b. Was decedent pregnant in the past 12 months?		th 2 Feta int at time of d		Ectopic pregna Other (specify				Month	Day Year
o,	the d the ched	iysi	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknow			3 0 11101 (0,0001)	/				
Δ.	that ed by deta	4	Part II. Other significant condition	ons contributing to dea	ath but not res	sulting in the u	nderlying cause	given in Pa	art I.	23e. Oid to	obacco use contribute	to the cause of death?
ds	sign d be	d by								101	res 2□No 3□F	Probably 4 Whiknown
ŏ	been	ete								04.145		
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	: Th										2 1 No 1 □ Ye	
Division of Vital	clen Sertiti ector	Be	25. Was case referred to medica examiner?	Hospital:		/	1		lace of Death	(Check only o	ne)	
1	this aldir	ို	1 Yes 2 No	1 In		ER/Outpatier	1 SEL DON				lence 6 □Other (Sp	ecify)
Ē	After Uner	Certification:	27. Manner of Death 1 □ Natural 5 □ Pendir	y I	, Day Year)	28b. Time of Injury		Injury at Work?		8d. Describe h	low injury occurred	
Sic	Attending or death. ector: Alter by the tune	cat	2 Accident investi 3 Suicide 6 Could	not be				1 ☐ Yes 2				
Ξ	iter d	E E	4 Homicide determ	inad 288. Place (of Injury - At hi g, etc. <i>(Specif</i>	om e, farm , str fy)	eet, factory, off	ice	2	8f. Location (8) City or Tow	Street and Number or F vn, State)	Rural Route Number,
	To the Mospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certilicate has completely litted in by the funeral director, page 2											
	Hosp 4 hou Fune ely ti	edical	(Check only 2 Medicel	Examiner: On the bas	sis of examina	owledge, deatl tion and/or in	occurred at the restigation, in re	e time, date ny opinion,	e and place, a death occurre	ind due to the old at the time, o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
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	1 × 0 0	~	29b. Signature and title of certifie	(1.		, , <		ense numb			29d. Date signed (Mor	
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	5	ĺ	30 Name and address of person	who completed cause	of death (Item	n 23a) (Type,	Print)	/	1	0.1	3/15/0	110
			XINNOU 1	L's alle	21	yan	cel- 11	ale	Oll	ndal	· 4/1/1	- M
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	dose	M. 3					
0.15	Registr	ar	MAR 1 9 2	007	Se Son	CARREL SA	A Comment					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sarah Louise 3/8/07 Hyde 1:30 pm /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6610 Allegheny Avenue Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5/12/47 **Funeral** Birthplace (State or Foreign Country) 1 M 2 TF 216-50-8256 59 Director Watertown, NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director Montgomery 1 Yes 2 No Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n 6610 Allegheny Avenue 20912 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ white 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) +4 Elementary/Secondary (0-12) Art Artist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Hyde Sarah Peavey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6610 Allegheny Avenue, Takoma Park, MD John D. Kline, Husband 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/14/07 Beltsville, MD Chesapeake Crematory 22. Name and Address of Facility Rapp Funeral and Cremation Svs. 21. Signature of Funeral Service License MO1358 933 Gist Avenue Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anaplastic Astrocytoma

Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed hysician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 1 ☐ Yes 2√☐ No 9 ☐ Unknown detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 TYes 2 No 3 Probably ∰Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed?

1 Yes 2 No funeral director, page certificate Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending To the nosperation within 24 hours after death.

To the Funeral Director: After the Funeral birds in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ö To the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 3/16/07 11864

Registrar

State

U

DHMH 17 Rev 1/2001

2021 K Street, N.W. Washington, DC 20006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. M. B. Dunn

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 14, Day 2007 Year **Physician** Gladys O. Hudson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Althea Woodlands Nursing Home 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Birthplace (State or Foreign NCCountry) If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 04/160/1920 **Funeral** Min Hours 1□M 2 F 181-16-4067 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland ment of Health and Mental Hyglene.
ant: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-f ehow ury or other traumatic event, "The Medical Exp. Inject must be redillated at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Rockville 1 Yes 2 No Montgomery Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852-USA 1000 Dale View Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes No Specify: Black Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Caregiver 15. Decedent's Education (Specify only highest grade completed) Homecare

Homecare Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Maude Della Webster Be John Edgar ၉ 19a. Informant's Name/Relationship (Type, Print)
James Gwyn/Son 19b. Mailing Address (*Street and Number or Rural Route Number*, City or Town, *State, Zip Code*) 1845 Harvard St. NW #623 Washington, DC 20009-20b. Place of Disposition (Name of Mar 21 2007 20c. Location - City or Town, State 20a. Method of Disposition Beltsville, Maryland 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee RappreFurnersion Eacoremation Services pro1358 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Assiration Pneumonia
Du to (or as a consequence of): 2 weeks Physician disease or condition resulting in death) /Medical Examiner 5ucr Disease tlzheimer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner physician and s the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Hoo 9 Unknown 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been signated to page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 22 No 2□ No 1 Yes 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Accident 5 Pending Within 24 hours after death.

To the Funeral Director: At 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number D 21900 3-15-07 Re 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #280 Takoma Park, MD Smith Ho, MiD. 7610 Carroll 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 9 2007 Registrar

			1 - For Amend Item Registrar	State of Is 24a,25,	Maryland / E 26,27,29 a	epartmen	t of H	lealth a	and M 3/19/	lental Hy '07dhb	giene	200	7	0.81	,73
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9	after or ite		1 Never Married 2 Married	Armed Force 1 Tyes 2 If Yes, Give		1 ☐ Yes, spec		in, Mexicar Specify:		Rican, etc.)		Black, V			
21215-0036	hours ural",	d by	3 X Widowed 4 □ Divorced	Year or Date								Specify: 1			
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Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature Fineral Since Lice	nsee	**************************************	22. Name an	d Addres	s of Facilit	ту.	1 (55 1		1			
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Pi (Check only one) 2 Medical Example 1	nysician: To the best miner: On the basis and manner:	of examination and	death occurred a or investigation,	at the tim in my op	ne, date an pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) date and	and manner place, and	r as sta due to t	ted. the cause(s))
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			30. Name and address of person who	completed cause of	death (Item 23a) (T	ype, Print)	, 0	Las	1	000	71-	201		Į.	
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	Registr		MAR 1 9 2007		K Goart										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2 Date of Death Month Year **Physician** WRCH 2:10 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOURS M 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 1 □ M 2 K F 219-10-8321 Director APRIL 62 1918 MARYlAnd Usual Residence of Decedent 10c. City, Town or Location 10b. County r 28a-f show notified at 10a State 10d. Inside City Limits 1XYes 2 No Director MARUIAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o 124 W. FRANKLin USA r Items 23a of Iner must be 31/881 21201 Completed by Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 22No Specify: Specify: AMERICAN 3 Widowed 4 □ Divorced "natural", traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, (DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Service 12# 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Stepp ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai - Baltimo e E. Date 20c. Lo 2016 KElbourne MARVA Grandbughtee MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MRRISON March 21 2007 OWINGE 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Ligensee 22. Name and Address of Facility WATEY M. WALLACE FURERAL SERVICE 3405 W- FRANKlin street-Bathinger MARY And 1219 23a. P. rt1. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships the unfailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and I-transit certificate be executed Due to (or as a consequence of) physician are the burial-t Box 68760 Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 ☑ No Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 | Unknown been signated Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has le 2 s autopsy page certificate 2 No 2□ No 1□ Yes Vital 25. Was case referred to medical examiner? Be director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3∏ DOA Certification: To 1 Inpatient 2 ER/Outpatient o this Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28d. Describe how injury occurred After t Division Hospital or Attending 1 Natural 5 Pending Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0030355 30. Name and address of person who completed cause of death SECOURS HOSPITAL (05/ 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Edwin S. Huson 03/ 14 2007 13:26 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Air, Maryland Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min. Months Davs Hours 1**☑** M 2□ F 01/26/1924 83 Pennsylvania Director 219-14-1037 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10h County r 28a-f show notified at 1 ☐Yes 2 No Director MD Baltimore Kingsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "naturai", or items 23a or 7417 Goettner Road 21087 U.S.A. Funeral Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland National College (1-4or 5+) Elementary/Secondary (0-12) Full Time Technician Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret B. Burkins Edwin M. Huson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 60 if of Health Eleanor G. Huson (wife) 7417 Goettner Road - Kingsville, Maryland 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/17/2007 Bel Air, Maryland Bel Air Mem. Gdns. 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee C 11750 Belair Road - Kingsville, Maryland 21087) assahn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** fau lure /Medical Due to (or as a consequence of): 3 Weeks Examiner Interstitial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner 3475 Renal chronic that initiated events resulting in death) Last Due to (or as a consequence of): THE BINE HE OND ON BOX 68760, attending physician for use as the buria pertension Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Anurymal 2 No 3 Probably 4 Unknown 1 □ Yes Aortic 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy performe 2 NO 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 Yes 2 No To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0018424 Mar- 15-2007

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2007

B.D. PAREKH

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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ORIGINAL

HARFORD ROAD, PALLSTON MD. 21047

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM/5 per FH, G*69, 7/25/07, WS
State of Maryland / Department of Health and Mental Hygiene

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1 D 57444 March 13, 20	707
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexander Chen MD PO Box 19099 Towson, MD 212.	84
State 31. Date filed (Month, Day, Year) Begistrar MAD 1 0 2007	-

07-01915	
Molly Harris	

Molly Harris	State of Maryland / D 1- For State Registrar	epartment of Certificate of			2007	0847
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Funeral	5. Social Security Number 6. Sex 7. Age (In	yrs_last birthday)	If Under 1 Year If Under 24	Irs. 8. Date of Birt	th (MM/DD/YYYY) 9. Bir	
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Balti permit Departim Imports injury o	21. Signature of Funeral Service Licenses		ame and Address of Facility ${f L}_0$			
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	Shorest Austra 11. MM)		O.C.M.E.		March 12, 2007	
9	30. Name and address of person who completed cause of death					
6	Pamela E. Southall, MD Assistant Medical		1 Penn Street, Baltimore	, MD 21201		
State Registra		Signature	W			

(athleen Haskin		1- For State Registrar	State of Maryla		artment of rtificate of		d Mental		Reg. No. 20	07 081,7
Physicia Medical Exami		Decedent's Name (First, Mickethleen Has	kins					2. Date of De Month March 14	Day Year 1, 2007	1636 FIFS
		4a. Facility Name (if not instituted Maryland General H		nber)	ľ	4b. City, Town, or I Baltimore	Location of De	ath	4c. County o	f Death
Funeral Director		5. Social Security Number 214-76-1960	6. Sex	7. Age (In yrs. Ia	ast birthday) 48 Yrs	If Under 1 Year Months Days	If Under 24h Hours M	Ain. 8. Date of B	1958	Birthplace (State or Foreign Country) MD
w any		Usual Residence of Decedent 10a. State 10b. Count	y	10c. City,	Town or Locati					10d Inside City Limits
with the Maryland ns 23a or 28a-f show be notified at once.	Director	MD 10e. Street and Number				Baltimo:			10g. Citizen of Wha	•
h with the ms 23a or be notifie	Funeral Di	2122 Mura St 11. Marital Status 1 X Never Married 2		edent Ever in U.		ZI: s Decedent of Hisp es, specify Cuban,			o- 14. Race - White,	USA American Indian, Black, etc.
s after deat ral", or ite	by Fun	3 Wildowed 4 Divorced in test diverted of the specific policy of Dales: 15 December 5 Education (Specific policy bishopt accept completed) 1160 December 11 Line Occupation (Size kind of we						can American		
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12				ost of working life. unknown				ıknown
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be Con	17. Father's Name (First, Middl	e, Last) rd Haskins			1		me (First, Middle,	Maiden Surname)	<u> </u>
22 Suld Me	To I	19a. Informant's Name/Relation Diane L. Saff	ship (Type, Print)				and Number of	or Rural Route Nu	mber, City or Town	
imore, MD 2 Pages 1 and 2 shounent of Health and 1 sant: If item 27 is root of other traumatic		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Removal from	m State	Place of Disposi crematory or oth	tion (Name of cerr er place)	netery,	Date	20c. Location - 0	City or Town, State
Baltimore, MD permit Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	j	Donation 5 Other 21. Signature of Funeral Service		Me	etro Crema 22. N	ame and Address	of Facility		eral Home,	
Physician /Medical		23a. Part I. Enter the disease, failure. List only one caus	complications that can e on each line.			e mode of dying,	such as cardia		more, Maryl rest, shock, or hear	
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c			th cocaine	use			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated	C							
0, be executed sician and ourial - transit	edical Exa	events resulting in death) Last X UNPENDED	dAMENDED							
sici		IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, or	utcomé of pregr	fancy	, perME, g	865, 3/3	-, -,	23d. Date of o	lelivery Day Year
Box 68766. he death certificate the death certificate the death certificate the deformance of the def	Physician/M	past 12 months? 1 Yes 2 No 9 V U		nt at time of dea	-4-	ner (Specify)				_
P.O	þ	Part II. Other significant cond	itions contributing to	death but not re	esulting in the u	nderlying cause gi	ven in Part I.			pute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 6876 is la to Attending Physician: The law requires that the death certificate is after death at Director: After this certificate has been signed by the attending phy led in by the funeral director, page 2 should be detached for use as the law that the funeral director, page 2 should be detached for use as the	Completed								psy pr	ere autopsy findings available for to completion of cause of eath? Yes 2 No
Vital I hysician: this certifi I director,	To Be	25. Was case referred to medic examiner? 1 ✓ Yes 2 No		patient 2	ER/Outpatient	100	of Death (Checother Nurs	sing Home 5	Residence 6	Other:
The state of the s									how injury occurre	d
Divisi ospital or Att hours after d meral Direct	Certification:	3 Suicide 6 X Co	28e Place		ome, farm, stree	t, factory, office bu	uilding, etc.			r or Rural Route Number, City Baltimore, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C	29a Certifier 1 Certifying one) 2 Medical Ex	Physician: To the best aminer:On the basis of and manner sta	examination ar	ge, death occun nd/or investigati	red at the time, dat on, in my opinion,	te and place, a death occurre	nd due to the cau d at the time, date	se(s) and manner a e and place, and du	as stated. e to the cause(s)
	Me	29b Signature and title of certification.		llah	V 3	29c. License O.C.N			29d. Date signed March 15, 2	d (Month, Day, Year) 007
6		30. Name and address of person Patricia Aronica-Poll		e of death (Item nt Medical E		111 Penn Str	eet, Baltim	ore, MD 2120)1	
St		31. Date filed (Month, Day, Year	9 2007 32 Re	strar's Signatu	ire # A	ale				

			For State Registrar	State of Maryland	d / Department of Certificate		Mental Hygien		08479
	Physici		1. Decedent's Name (First, Middle, Las	ROBERTA	7 JAC	KSON	2. Date of Death	ay 200	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give	ARE OF G	ANION TE	wn, or Location of Death	E	c. County of Death	
	Funeral Director		5. Social Security Number 6. Sec. 11 Usual Residence of Decedent	7. Age (In yrs. la		Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, Yea	9. Birth Con	nplace (State or Foreign untry)
	ith the Maryland or 28a-f show	ctor	10a. State 10b. County	A B	Town or Location ALT MOR	E			10d. Inside City Limits 1 Pres 2 No
	h with the	al Director	10e. Street and Number 136 S: ELA	LWOOD	AVE. 101. Zip Ci	21224	10g. (Citizen of What Col ک - ک	untry?
920	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland to f Health and Menial Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event, Its Mardical Examinar must be mailfied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Deceder If Yes, specify	nt of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	within 72 ho ene than "natur tre wedical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Usual ((Give kind of work life. DO NOT use)	done during most of worl	sing 16b.	Kind of Business/I	Industry S Hon
Maryland 2	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, its M.	To Be Co	17. Father's Name (First, Middle, Last)	ROWELL		18. Mother's Nam	e (First, Middle, Maide Z TA	on Sumame)	
	and 2 sho fealth and P m 27 Is me ther treums		19a. Informant's Name/Relationship (7 EARL JACK 20a. Method of Disposition	SON	19b. Mailing Address (S	Street and Number or Ru	D AUE.	or Town, State, 2 BALTE Location - City or	5-, MD.
Baltimore,	t. Pa tmen tent:		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	EHDEU A	DEE MAK	2007 H	DUE ALD	Co, MD
Ba	Depar Import any ir		Mekomas .	Spardo K	Do not enter the mode.	DA FIH	or respiratory arrest	to. Mi	Approximate
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequ	red De	mento	•		Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	太s ulco	¥ ·			
8760,	ate be executed obysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a consequent	ience of):				
Box 6	ie death certific the attending p hed for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic preg			23d. Date of deli Month	ivery Day Year
ds, P.O.	juires that the signed by ald be detacted		Part II. Other significant conditions co	ontributing to death but not resu	Ilting in the underlying cau	se given in Part I.		b. 4	the cause of death?
of Vital Records,		Completed					24a. Was an autopsy performed?	prior to d	topsy findings available completion of cause of
f Vita	Physician: The this certificate he ral director, page	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 DOA		th (Check only one)	6 ☐ Other (Spec	cify)
ion of	inding Phath. ir: After the		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury M	. Injury at Work? 1 Yes 2 No	28d. Describe how in		
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify	")		28f. Location (Street City or Town, Sta	ate)	
	ne Hosp n 24 hou ne Fune pletely fil	edical		ysicien: To the best of my know linar: On the basis of examinat and manner stated.					
	To the Ho within 24 To the Fu completel	M	29b. Signature and the of certifier	>.		icense number	29d. [Date signed (Month	2
	4		30. Name and address of person who of SCR AS TIAN J	completed cause of death (Item	23a) (Type, Print)		Bothmare	MO	21224
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 9 2007	32. Registrar's Signat					

		4	For State Registrar	State of Marylan		artment of H			iene) () () ()	08480
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia Medic/		Lawrence Norbert	Juchs				March	13 200	7 1:39 P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of De Baltimo	re County
	Funeral Director		5 Social Security Number 6. S		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 12	Year) 9. B	orthplace (State or Foreign Country) 1timore, Md.
	9		Usual Residence of Decedent	10.00	Ŧ					10d. Inside City Limits
	Marylar a-f show	tor	Maryland Baltimo		r, Town or Lo	ocation				1 ☐ Yes XX No
	3a or 284	I Direc	10e. Street and Number 11116 Old Carriag	e Road		10f. Zip Code 21057			og. Citizen of What C United St	•
36	within 72 hours after deeth with the Maryland ene. than "naturs!, or Iteme 23a or 28a-f show ha Medleal Examinat mad Le modified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh Specify: W	ite, etc.
Maryland 21215-0036	in 72 hou n"natura ledical E	Completed	15. Decedent's Ec (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wor		16b. Kind of Busines	s/Industry
212	iene.	E	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Assi	stant Pr	inciple		Baltimor	e Co. Schools
and	d be filed intal Hyg ad othe	Be	17. Father's Name (First, Middle, Last) Lawrence John Juc			A Administration		ne (First, Middle, I ne E. Sap		
2	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if itsm 27 is marked other than "naturs!", or iteme 23a or 28a-1 show any injury or other traumatic svant, the Medical Examinar mant be inclined at Quee.	ို	19a. Informant's Name/Relationship (Type, Print)					City or Town, State	
Ž			Mrs. Jean S. Juchs (Wife) 11116 Old Carriage Road, Glen Arm 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Loc							
Baltimore,			20a. Method of Disposition 1XXSurial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State	emetery, crei	osition (Name of matory or other place Iem. Gdns	. March		20c. Location - City of Belair, M	
Balt	permit. Departr importu		21. Signature of Funeral Service Licer	Lehm	Pe 23	Name and Address Caceful A. 325 York I	iternativ Road, Tin	ves Funer nonium, M	al&Cremat Maryland 2	ion Ctr.,P.A.
)	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease of common shock, or heart failure. Eist only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	b. Due to (or as a consequence) C	ncreof):	/	g, such as cardiad	or respiratory arr	est,	Approximate Interval Between Onset and Death 7 men 4h5
68760,	eath certificate be executed attending physicien and for use as the burial-transit	dical	resulting in death) Last	Due to (or as a conseq	uence of):					
P.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3[Ectopic pregnancy Other (specify)	,		23d. Date of o Month	lelivery Day Year
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Division of Vital Records,	The law requir ate has been s page 2 should	Completed						24a. Was a autops perform	med? prior t	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
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<u></u>	Physic this c	၉	1 Yes 2 No		ER/Outpaties 28b. Time of		4 🗀 (Yul Silly I		ence 6 Other (S)	pecify)
ion	Attending F r death. sctor: After by the funer	atlon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		Injury	Wor	k? Yes 2□No	20d. Describe in	ow injury occurred	
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	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funstal Director: After this certificate has completely illed in by the funeral director, page 2	edical C		nysician: To the best of my kno niner: On the basis of examina and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	In De o		29c. Licens		2	9d. Date signed (Mo	nth, Day, Year)
•	20		30. Name and address of person who	completed cause of death (Item		Print)	0 30/22	//	1 a	44
	of -		Lawrence J.	Snyder 7505 32. Agistrar's Signa	Osler	- Pr 308	Tows	on , mo	1. 2120	4
3:	Sta Registi		31. Date liled (Month, Day, Year) MAR 1 9 2	2007 Source J	de for	and I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8 per Th 9865 3-20-07 vt.
State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MILLARD C. JENKINS JR. Mar 15 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE UNION MEMORIAL HOSPITAL Date of Bid 924 (Month, Day, Year) 12-4-192 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days TENN Months Hours Min 412-22-7321 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No BALTIMORE Director N/A MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 USA 727 DRUID LAKE SR APT 7E Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation. 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than "I Elementary/Secondary (0-12) -12-College (1-4or 5+) FITNESS ASSISTANT WELLNESS CENTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JESSIE BASS MILLARD JENKINS, SR. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 s nent of Health an of Health COBB CREEK PKWY. PHILADELPHIA, PENNA. 19143 RECARDO MILLARD (BROTHER) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any Injury or o 1 Burial 2 Cremation 3 Removal from State GARRISON FOREST VETERANS 3-23-2007 OWINGS MILLS, MD. 5 Other (Specify) 4 Donation al Serve dens e JON THA HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. - 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, br heart fallure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Due to (r as a consequence of): Physician day /Medical Examiner neumoni Sequentially list conditions, it was a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner attending physician and for use as the bunal-transit the death certificate be executed Cancer Lung Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 1□ Yes 2 No certificate or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 XÎnpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at After Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AT2438946 Mar 15, 2007 Lew M. D 30. Name and address of person who completed cause of death (16th 23a) (Type, Print) Union Memorial Hospital MD 19 M.D. Registrar's Signature Chung 31. Date filed (Mon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death edent's Name (First, Middle, Last) Day 6:55 ohnson Physician lildred Mürch 0 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** 3613 Croudon 120 - IMORE If Under Year | If Under 9. Birthplace (State or Foreign Country) MCNIGAN 8. Date of Birth (Month, Day, (an 2), 5. Social Security 1374-39-1780 Social Security Number 7. Age (In yrs, last birthday, **Funeral** Days Hours 1 M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No ral", or items 23a or 28a-f st Examiner must be notified Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No altimore, Maryland 21215-0036 Specify. Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a Decedent's Usual Occupation 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be and Mental ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number Informant's Name/Relationship (Type. Print) City or Town, State, Zip Code) 19a. Department of Health ar Important: If item 27 is any Injury or other trauonce. 20b. Place of Disposition (Nar cemetery, crematory or o of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation *) 5 ☐ Other (Specify) 22. Name and Address of Facilit 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Fredhilton Russ Balto mo alazo Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) , Physician Imyotophic Vears /Medical Due to (of as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforr 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 KResidence 6 □Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: Director: / within 24 hours at To the Funeral C

28a. Date of Injury (Month, Day Year) Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

(Check only one) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

16 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1830 € Baltimore, Monument hankes 31. Date filed (Month, Day,

State Registrar

Medical

2007

uen Mo

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

1- State Amend #5, perFD G865, 3/26/07 TT Contificate of Decimal Property of Decima 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Keyes Emma Μ. Year :45 PM /Medical 2 6 07 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Himore Hospita If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 86 Yrs. Social Security Number 6. Sex **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) -137 0137 217-07-1 □ M 2 🕅 F Months Days Hours Min Director 10-16-1920 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits at a or 28a-f sho be notified a Maryland Baltimore Director Parkville 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Examiner must b 3504 North Wind Road 21234 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Kelbel ၉ Margaret Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 North Wind Road Carole Miller - Daughter Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 03/21/2007 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Charles Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to lo al a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner System Organ Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as use. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant et time of death Year 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð pe ¥ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed certificate 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) S No Hospital: 1 Tes P 1 npatient 2 ER/Outpatient 3 DOA this within 24 hours after geam.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 17 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Emma

State Registrar

29b. Signature and title of certifier

31. Date iffed (Month, Day, Year)

Behar

DnAjay

DHIVIH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature

ORIGINAL

Franklin Square

Drive, Baltimore

29d. Date signed (Month, Day, Year)

Krasnodemska, Helen

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			- FOI	State of Maryland / Department of Health at	nd Mental Hygier	1e 2007 001.0	1.
		-	State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. I	No. (_ U U) U U U U U U U U U U U U U U U U	1 11
	Physici /Medic		HELEN K	RASNODEMSKA	Month 1	3 2007 9:50 A	
	Examin	er	4a. Facility Name (If not institution, give s Franklin Squa 5. Social Security Number (6. Sex	reet and number) 4b. City, Town, or Location of POSEAA 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	Hrs. 8 Date of Birth	Beultimaye 9. Birthplace (State or Fore	eian .
h	Funeral Director			M 2007F S/ Yrs. Months Days Hours	Min. (Month, Day, Yes	ar) 935 Country) M.D.	
	f show	ō	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Lim 1	- 1
	vith the N or 28a-i be notifi	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?	
	ter death v items 23a Iner must	Funeral	11. Marital Status 1 □Never Married 2 □ Married	2. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origing If Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
-0036	n 72 hours af "natural", or edical Exa <u>ml</u>	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates: 1 ☐ Yes 2 ☐ No Specify: ation 16a. Decedent's Usual Occupation	[16b.	Specify: SALL TE	_
21215-0036	withir ene. than	Completed	(Specify only highest grade		of working	D WIN HOME	
Maryland	2 should be filed and Mental Hygin Is marked other aumatic event, the	To Be C	17. Father Name (First, Middle, Last)	CRASNODEMSKA VE	s Name (First, Middle, Maid LENICA L	en Syrname)	
, Mary	1 and 2 short Health and Niem 27 Is ma		19a Informant's Name/Relationship (Type)	e. Print) 19b. Mailing Address (Street and Number 108 4 CHSHIR	or Rural Route Number, Cit	y or Town, State, Zip Code (1) 223	ζ
altimore	Pages 1 and of He	Ì	20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 16 20c.	Location - City or Town, State	
Balti	permit. Pag Department Important: I any Injury o	, 1	21. Signature of F. neral Service License	Ball 22. Name and Address of Facility	1. 2529/10	PSON STIZEL	
0	Physician	(5 J	Immediate Cause (Final	ations that caused the death. Do not enter the mode of dying, such as coaus in each line.	ardiac or respiratory arrest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		disease or condition resulting in death)	Dur to (or as a consequence of): Arthropic clarity Heart	Disease.	10 years	
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	1301030	7200	
, 092	ite be executed lysician and ne burial-transit		resulting in death) Last	Due to (or as a consequence of):			
Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. If yes, outcome pf pregnancy 1		23d. Date of delivery Month Day Year	
P.0.	that the o		9 ☐ Unknown	9□Unknown ributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?	,
ords	w requires been sign should be	eted by	Insulin Dep	pendent Diabetes Mellitu	_S 1 □ Yes	2 No 3 Probably 4 Unkno	
Division or Vital Records,		Completed	OF Was seen referred to modical	00 P	24a. Was an autopsy performed		of
Ξ	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	penital: /	of Death <i>(Check only one)</i> sing Home 5 \(\subseteq \text{ Residence} \)	e 6 ☐Other (Specify)	
o uo	iding Ph h. : After th funeral	tion: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M 1 □ Yes 2 □ N	28d. Describe how in		
Divisi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)	
	he Hospit n 24 hours ne Funera	Medical C		ician: To the best of my knowledge, death occurred at the time, date and er: On the basis of examination and/or investigation, in my opinion, death and manner stated.			
\	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)	
	N		30. Name and address of person who co	ppleted cause of death (Item 23a) (Type, Print)	Drive Bart	212101	
	Sta	te	31. Date filed (Month, Day, Year)	22 Aegistrar's Signature	DITTE DUT	J., 1"10 442/	
	Registi	ar	MAR 1 9 2007	ACADEN ST ROBARA			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Eloise Irene King also /Medical 4c. County of Death Baltimore City 4a. Facility Name (If not institution, give street and number)
Genesis Eldercare Hammonds Lane 4b. City, Town, or Location of Death Baltimore Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 ☐ M 2 🔀 F 21910 4996 February 16 1914 Williamsburg,MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir then "natural", or items 23a or 28a-f ehov the Medical Examinar must be notified at Baltimore County 1 Yes 2 No Maryland Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21220 1207 Tarrytown lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 **KX**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 20X No Specify: Specify Completed by White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Police Dept. Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event one. Be Grace Richer Robert Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1207 Tarrytown Lane Baltimore, Maryland 21220 Joyce A Fischer 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. March 16 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signature of Funeral Service Licensee Son 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician MINOMUSATA /Medical Due to (or as a consequence of) Examiner Stage End Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of and Il-transit Due to (or as a consequence of): physicien a s the burial-Physician/Medicai ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one)

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: A

After

within 72 hours after death

State Registrar 29b. Signature apartule of certifier

31. Date filed (Month, Day, Year)

Jude Myneres mo

MAR 1 9 2007

DHMH 17 Rev 1/2001

MD

30. Name and accress of person who completed cause of death (Item 23a) (Type, Print)

7845

32 Registrar's Signature

29c. License number

053462

DATWOOD ROOM Glen Burnie MD 21061

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14 2007 ar **IRIS** MARCH KOTZ RITA 9:30 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7219 PARK HEIGHTS AVENUE APT. 107 BALTIMORE If Under 1 Year If Under 24 Hrs. Mapths Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 01/23/1927 213-20-4674 80 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A 1 √Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7219 PARK HEIGHTS AVENUE #107 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>HOMEMAKER</u> OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS CRYSTAL **EMMA** BARR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONARD KOTZ / HUSBAND 7219 PARK HEIGHTS AVENUE #107-BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CONG. 03/16/2007 FINKSBURG, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Success 9h 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr specified. PIKESVILLE, MD 21208 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Urinony Seplis Due to (or as a consequence of Obstructive Sequentially list conditions, if any, leading to infined ate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last uruputh Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pneumone 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examinar ministration.

Baltimore, Maryland 21215-0036

Examine physician the as attending j ed by the ate has been sign page 2 should be director.

The law requires that the dath cartificate be executed

P.O. Box 68760,

Division or Vital Records,

Attending Physician:

\$ Completed certificate Be 2 this Certification: : After 1 or Attendater death /sp., _4 hours al., ≥e Funeral Direc., ≤e filled in by th∕

To the vithin 2 Registrar

Physician/Medical

27. Manner of Death

Medical

State

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

5 Pending investigation

28a. Date of Injury

28h Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

019914

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

mal 2/093

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and add ss of pers leted cause of death (Item 23a) (Type, Print)

A STATE OF

10753 FMs Rd Luther, lle 32. Registrar's Signature

31. Date filed (Month, Day, Year) MAR 19 200 Goods

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 🔒 🧎 🧻 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16 COMP /Medical Randalstown 9109 Liberty IV.

6. Sex 7. Age (In yrs. last birthday).

7. Sey Yrs. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rand Alls to Un MD 21/33 SAI timure 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign Days Hours Director Mary Tand Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Important: If Item 27 is marked other than "naturer, or Items 23a or 28a-f ahow any Injury or other traumatic event, the Madical Examiner must be accepted. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Director Baltimore 1x Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2803 Bayonne Ave. 21214 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑No Specify: 3 ☐ Widowed 4 ☑ Divorced Specify: White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working College (1-4or 5+) Elevator Dispatcher 12 Office Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George A. LeCompte Katie J. Knefely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Katherine C. Watson / Daughter 2803 Bayonne Ave., Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/16/2007 Towson, MD 21. Signature of Funeral Service Livensee Charles F. Miner Name and Address of Facility Baltimore, MD 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the diff ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced demention **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of). Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-trant Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 month 3 Ectopic pregnancy 4☐Pregnant at time ot death Month Day 5 Other (specify) ed by the detached 9 Unknown certificate has been signed rector, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 3 Probably 4 □Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: ٩ 1 □ Yes 2 □ 1 € 1 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Hursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending after death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 10 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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Division of Vital Records, P.O. Box 68760, Hospitel or Attending Physician: 24 hours after of Funeral Direc filled in by completely To the

> State Registrar

31. Date filed (Month, Day, Year) MAR 19

296. Signature and title of certifi

(Check only

-Sayed 32. Registra s Signature

of person who completed cause of death (Item 23a) (Type, Print)

Liberty Road

29c. License number

29d. Date signed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Lang MAR /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Year If Under 24 Hrs. NSVI 9. Birthplace (State or Foreign Country) urity Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or Items 23e or 28a-f show eny injury or other treumatic event, Ite M other Expreter must be putful at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Completed by Funeral Director TOPS VILLE 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Two
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2010 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Securitary (0-12) College (1-4or 5+) HOME 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Superal Service Licent 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebral Physician Thrombosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: . If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) detached ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 2 1 No 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Nerel Director: After the filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide hours after within 24 hours a To the Funerel (1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 00053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Md Smith Avenue 2835 Spark 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 9 2007 Registrar

			For State Of IV.		artment of Health and rtificate of Death		giene Reg. No. 0 0 7	08489
30			Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death
	Physici /Medic		ROBERT PROCTOR LINZEY	,SR		March	Day 200 Tear	0645 M
	Examin	- T	4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location of De		4c. County of Deat	
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	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	peation			10d. Inside City Limits
	with the Maryland a or 28a-f show be notified at	ō	MD		altimore			Y∏Yes 2 ☐ No
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	ne 23	Funerai	11 Marital Status 12. Was Decedent	t Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No		
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036	al', o	by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 X No Specify:		Specify:	White
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2	be filed withital Hygiene. d other than	Ço	12	100			School	S
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Jar	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens Important; if item 27 is marked other than "any injury or other traumatic avent, Ins. Market.		19a. Informant's Name/Relationship (Type, Print) Mike Linzey-Son		ng Address <i>(Street and Number or</i> Carlton Way-Be			
, _			20a. Method of Disposition	20b. Place of Dispo		Date	20c. Location - City or	
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Baltimore, Maryland 21215-003	it. P.	-	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	CREMATION S	FRVICES Ballair	-20-07	Forest Hill	
Ba	Depa Impo any i		Condrae h ME tudo	du E		CHAPEL	8800 Harf Parkville	ord Road ,MD 21234
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LINZEY

Robert P.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LEISTER **Physician** 750 PM 2007 MAR /Medical 4b. City. Town, or Location of Death 4c. County of Death **Examiner** OF MARYLAND MED CENTER BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 5, 1917 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🔀 F 90 186-14-3212 Feb. Pennsylvania Director Usual Residence of Decedent the Maryland a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 1305 Providence Road 21286 'natural", or items 23a dical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No ð Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant +2 Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic even Thomas E. Kerr Lucy Μ. Blemings 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other trau 1305 Providence Road Towson, Md. 21286 Miss Margaret Leister/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Co. 3-17-07 Towson, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeful Service Licensee Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deati Immediate Cause (Final disease or condition resulting in death) Myocardia Physician DUCIE /Medical Due to (o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trai Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 9□Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 No 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 2 ER/Outpatient 3 □ DOA 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

Medical Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29b. Signature and title of certifi Mr. D. 15818 MAR 15

Mo completed cause of death (Item 23a) (Type, Print)

O. 1 22 South Greene Street, Baltimore, Mayland 21200

Begistrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Maklachi, W.D. Date filed (Month, Day, Year) 9 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend itel 10c per th 9865 3-19-07 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 0.91.91. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH TRUDI LEE LESSER 2007 6:14P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4 BLACK CHERRY COURT REISTERSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/28/1936 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M Months Hours Yrs 467-54-7668 70 NY Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show a or 28a-f sh t be notified REISTERSTOWN 1 Tes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a c 4 BLACK CHERRY COURT U.S.A. 21136 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ö Specify Specify: 3 ☐ Widowed 4 X Divorced WHITE "natural" Completed permit. Pages 1 and 2 should be filed within 72 hi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FLORAL DESIGNER FLORAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SIDNEY CLAIR **FRANCIS** မ ALLWEISS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORI JOSEPH / DAUGHTER 421 DOE MEADOW DRIVE-OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ARL'INGTON A'CHIZUR' ACE 03/15/2007 BALTIMORE, MD 4 Donation 5 Other (Specify) AMUNO CONG. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final Candiovascular Physician rterioscleratio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events and j physician an resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ■ No 24a. Was an autopsy performed? Yes 2XINo 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifi

State Registrar

DHMH 17 Rev 1/2001

Militello 31. Date filed (Month, Day, Year)



Trimble

who completed cause of death (item 23a) (Type, Print) 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep	rtificate of Death	Re	g. No.?	08492
ļ,	Physicia	n	1. Decedent's Name (First, Middle, Last) John Joseph Mooney, Sr.		2. Date of Death Month March	15, 2007	3. Time of Death 2:42 P.M
0	/Medic Examin	_	4a. Facility Name (If not institution, give street and number) 830 South Luzerne Avenue	4b. City, Town, or Location of Death Baltimore		4c. County of Death	1
	Funeral Director		5. Social Security Number 214-22-5139 6. Sex 1 M 2 F 79 Yrs.		8. Date of Birth (Month, Day, Sept 1	Year) 9. Birth Co., 1927 Ma	nplace (State or Foreign intry) aryland
	D		Usual Residence of Decedent 10c. City, Town or L 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Maryf i-f sho fied a	to	Md. Baltim	ore			1♥ Yes 2 No
	with the	I Direc	10e. Street and Number 830 South Luzerne Avenue	10f. Zip Code 21224	10	U.S.A.	untry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. I Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show them 27 Is marked other than "natural", or Items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Wes 2 □ No If Yes, Give Year or Dates: WW II	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto			Nhite
21215-0036	in 72 hou "natura Aedical E	Be Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	king	16b. Kind of Business/l Independe	ent
212	d with glene. er thar	E C	8th Mac	thine Operator	ne (First, Middle, I	Can Compa	ny
g	be file ntal Hy ed oth	Be (17. Father's Name (First, Middle, Last) John C. Mooney		Luckhar		
Maryland	should nd Men marke matic	잍	· · · · · · · · · · · · · · · · · · ·	ling Address (Street and Number or Ru			Zip Code)
	and 2 sealth ar n 27 ls		Robert Patrick (step-son) 200	5 Jasmine Road	Baltim Date	ore, Mary	land21222
ore,	jes 1 a for Hea if Item or othe		20a. Method of Disposition 20b. Place of Discemberry, circles 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	position (<i>Name of</i> ematory or other place) leart of Jesus Marc		•	
Baltimore,	permit. Pages 1 Department of F Important: If Ite any injury or of		4 Donation 5 Other (Specify)	22. Name and Address of Facility & a C	czorows	ki Funera	al Home, PA
Ba	Depa Impo any i		Teliat Vzorlan	201 Dundalk Ave			
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	1			
	Examiner		Sequentially list conditions. b. Parkusons	Disease			
	bed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
oʻ	iicate be executed physician and s the burial-transit	Ехаг	that initiated events c				
68760,	ate be ohysicia the bu	edical	d				
Box (death certifi e attending d for use as	by Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	elivery Day Year
s, P.0	requires that the leen signed by the hould be detache	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did to	obacco use contribute t ∕es 2 万 No 3☐ F	to the cause of death? Probably 4 □Unknown
Records,	requir been si should	Completed	F		24a. Was	an 24b. Were a	autopsy findings available completion of cause of
	sician: The law certificate has b irector, page 2 sh	dmo			autop perfo 1∐ Yes	rmed? death?	s 2 No
or Vital	striffical ctor, p	Be C	25. Was case referred to medical examiner?	Other	ath (Check only o		
or V	rding Physician: h. : After this certifica funeral director, p	2	1 Yes 2 No ruspiral. 1 Inpatient 2 ER/Outpa	e of 28c. Injury at	_	dence 6 Other (Sp now injury occurred	ecify)
On	Attending r death. sctor: After by the funer	tion	1 X Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	or Atte after des Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At home, farm building, etc. (Specify)	street, factory, office	28f. Location (3 City or Tou	Street and Number or F vn, State)	Rural Houte Number,
	To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do not b	eath occurred at the time, date and place or investigation, in my opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	Fo the within 2 Fo the comple	Med	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	/
	- > - O		Mushinasmo	D458+6		March	16/2007
	lotor		30. Name and address of person who completed cause of death (Item 23a) (Ty	Baltmure	mo.	21236	
	\$	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	D45876 Baltonure			
ĺ	Regis		MAD 1 9 2007 Degras Do 1				

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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BOWIE, MD 20715

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

115/2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Helen Mazz March 9, Bond 2007 /Medical 7:50 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Alangha Dave Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F Director 89 220-09-4719 Feb. 13, 1912 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a 715 Maiden Choice Lane, CC206 21228 Funeral USA "natural", or items edical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Completed by 3 Midowed 4 Divorced Specify: White permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical I once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Circut Court of Balto. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John Ross Bond Mary Dorcas Kirkwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy R. Thompson (Niece) 227 Longwood Lane, Bluemont, VA. 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3/17/07 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part: Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician theroscler disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician the dolor in the burian Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 Yes 2 □ No 9 □ Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has After this certificate 1∐ Yes 2□ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) WD 13.2007 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 gre [9211S Maide N010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 346 A-M a0074c. County of Death 4h City Town or Location of Death Name (If not institution, give street and number) Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 912142 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 64 Months Days Country) 1 M 2 F Yrs 60 WV Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 □ No XX **BROOKLYN** MD ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 USA 4113 HAGUE AVE. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, GiveXX 1 ☐ Yes XX No Specify: Specify. 3 Widowed 4 Divorced Year or Date WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AVON 12 SALES REP 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) COLLEEN MARIE STURMS ALVA GEORGE PHILLIPS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4113 HAGUE AVE. BALTIMORE, MD 21225 NELLIE J. MULLINS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State GLEN BURNIE, MD **GLEN HAVEN CEMETERY** 3.7.2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY S. GLEN BURNIE, MD 21061 21. Signature of Funeral Service K. GREGORY M01148 Approximate Interval Between Onset and Death 23a. Pan1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease of condition metastatic adenocurcinoma resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 Tes 2 🗌 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform o? Yes 2 1 No

Physician /Medical Examiner

Physician

**/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be ပ

Funeral

Director

If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

al Hygiene.

Pages 1 and 2 should be file report of Health and Mental Hitant: If Item 27 is marked oth

permit. Pages 1 Department of H important: If Ite any Injury or ot

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed the burial-transit physician use as ğ signed by the a

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

To the

Examiner page 2 s certificate director Certification: To this funeral Affer ours after death.
neral Director: A
filled in by the fu

Completed by Be

Physician/Medical

within 24 hours a To the Funeral L 29a. Certifier Medical completely 29b. Signature and title of cepifier

O State Registrar

31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

MD

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

1 Inpatient

28a. Date of Injury (Month, Day Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

28b. Time of

Injury

29c. License number

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

3□ DOA

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1☐ Yes

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specity)

28d. Describe how injury occurred

26. Place of Death (Check only one)

cause of death (Item 23a) (Type, Print) 30. Name and address of person who com MEDICAL CUT, BALTIMORE MD Sandra Rub MD

> egistrar's Signature 9 200



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MARCH 18, 2007 3:10 P THOMAS E. MANDLEY, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL MARINER OF GLEN BURNIE **GLEN BURNIE** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Sex XM 2□F **Funeral** Hours Davs Months MD 89 MARCH 20, 1917 Director 214.01.4837 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐Yes 2☐No Director ODENTON MD ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 1939 ARTILLERY LANE 21113 Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**XX**No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CAPTAIN MARYLAND STATE POLICE 11 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fill of Health and Mental H CLARA LINK THOMAS MANDLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1939 ARTILLERY LANE ODENTON, MD 21113 SON THOMAS E. MANDLEY, JR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 3.19.2007 BAYVIEW CREMATORY INC BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY S. GLEN BURNIE, MD 21061 21. Sign (10) Funeral Service License Messey K. CRECORY FINE M01148 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between 23a. Part1. Enter the disease, shock, or heart failure. L Onset and Death Immediate Cause (Final disease or condition resulting in death) OLAR **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Ulknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours af le Funeral D letely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29c. License number 29b. Signature and title of certifier 223130 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) 3927 ANNAPOLIS ROM 21227 TTENJEG SHOK 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Ma	ryland / Depa	artment of F			iene 0 0	7 03497	
	Physici	an	1. Decedent's Name (First, Middle,		larell			2. Date of Deal Month	Day	3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 334 Wild Willow Way			4b. City, Town, or Location of Death Severn			4c. County of	4c. County of Death ANNE ARUNDEL CO	
	Funeral Director		5. Social Security Number 207389622 Usual Residence of Decedent	6. Sex 7. Age	(In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Sept. 17	(1948)	B. Birthplace (State or Foreign Country)	
5-0036	72 hours after death with the Maryland natural; or items 23a or 28a-1 show dical Examinat De Indilled at	Irector	10a. State 10b. County PA Bucc 10e. Street and Number		10c. City, Town or Lo Levit			4	0g. Citizen of Wh	10d. Inside City Limits	
		ed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:		Black,	American Indian, White, etc. Black	
21215	filed within 72 Hygiene. Ither than "na ont, the Medic	Completed	(Specify only highest	College (1-4or 5+	(Give	kind of work done DO NOT use retired hers A	during most of world) SSISTATE	rking	School	System	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be a cutified an once.	To Be	17. Father's Name (First, Middle, L William Fire 19a. Informant's Name/Relationsh	izier	19h Maili	ng Address (Street	Gertr	me (First, Middle, I	sarre	14	
Baltimore, Ma			20a. Methód of Disposition 1 Source 2 Cremation 4 Donation 5 Other (Sp. 21. Signatur 4 Funeral Service L	1-Beil da	20h Place of Dispo	sition (Name of natory or other place) Coccl Cern (2. Name and Addre	Willow (ce) Mar eferil ss of Fability [4]	Va: 5.0 17,2007 ACKET	evern, 1 20c. Location - C Hamil 15 Fu		
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or polytical productions.	Completed by Physician/Medical Examiner	23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date Monti		
								23e. Did tob	tobacco use contribute to the cause of death?] Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
								24a. Was a autops perform	y pri	ere autopsy findings available or to completion of cause of ath?	
		Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigs 2 Accident investigs 3 Suicide 6 Could no	26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 28c. Injury at Work? M 1 Yes 2 No			ence 6 XOther	njury occurred			
			4 Homicide determin	building, etc.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) nysician: To the best of my knowledge, death occurred at the time, date and place		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Medical	(Check only one) 2 Medical E	xaminer: On the basis of e	examination and/or in	vestigation, in my o	pinion, death occu	irred at the time, da	ate and place, an	d due to the cause(s) Month, Day, Year)	
	0		Jil (-m	Z n	ath /Item 23a) (Tyne		8320		3/13/0	7.	
	10		30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) 「シトン「ユー・ハイ・10753 「イニン パム・ルップ・ルイン 21093, 31. Date filed (Month, Day, Year) 32 Registrar's Signature								
	State Registrar MAR 1 9 2007 33 Registrar's Signature										

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Adele March 16, Ovelgone 12:50 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FutureCare Canton Harbor Nursing Ctr Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 ☐ M 2½ F Director 218-16-2353 80 July 29,1926 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8157 Kavanagh Road or Itams 23a United States 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify þ Specify: 3 Widowed 4 Divorced White 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 271s markad other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 Vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cecilia Rudzinski Adam Popowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Henry G. Ovelgone (Husband) 8157 Kavanagh Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State ö ' 4 ☐ Donation 5 ☐ Other (Specify) injury 3/19/2007 Baltimore, Maryland Lawn Cemetery 21. Sign ture uneral Service License 22. Name and Address of Facility once any i Duda-Ruck Funeral Home of Dundalk, Inc. 21222 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Priysician /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and Due to (or as a consequence of): as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy jo Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes P this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No in by the 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 - Homicide 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 1801 JONat 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** OWINGS MARCH EDWARD 14,2007 7:07F M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Towson Baltimore Center Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1**X** M 2 □ F Days Hours Director 220-22-5097 7/13/1928 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits 28a-f show notified MD BALTIMORE RIDGELEIGH 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with anent of Health and Mental Hygiene. Interest of Health and Mental Hygiene. It it item 27 is marked other than "natural", or items 23a or any or other traumatic event, the Medical Examiner must be. 8544 WATER OAK ROAD Funeral 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: KOREAN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9TH GRADE FIREFIGHTER BALTIMORE CITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ CHARLES OWINGS HELEN BAKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: if item 27 is any Injury or other trauonce. BALTTMORE, MD 21234 Date 20c. Location - City or Town, State MARY OWINGS/WIFE 8544 WATER OAK ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CENTRE PRESBYTERIAN 3/19/2007 NEW PARK, PA 4 Donatjon 5 Other (Specify) CEMETERY Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatur of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 art¹. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Year Month Day 5 Other (specify) 0 1 ☐ Yes 2 ☐ No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by CONGESTIVE HEART FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an LUNG CANCER IN REMISSION autopsy perforr certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 ☐ Pending investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours af To the Funeral D completely filled in To the Hospital Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D31189 MARCH 15, 2007

Registrar DHMH 17 Rev 1/2001

State

MICHAE

31. Date filed (Month, Day, Year)

M.D.

7601 OSLER DRIVE TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (item 23a) (Type, Print) JOSE MINISOHN

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** F. 3:00 A M Benjamin Pacitto, Sr. 14, 2007 March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Maryland Edgemere 2326 Sparrows Point Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **™** M 2 □ F Yrs. Director 218-30-6269 Feb. 28,1935 West Virginia Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🍇 🕏 No Directo Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2326 Sparrows Point Road 21219 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Steelworker Steel Industry permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Pacitto Mary Domico 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Pacitto (Wife) 2326 Sparrows Pt. Road Edgemere, MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 4 Donation 5 Dother (Specify) 3/17/2007 Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, I 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) geous **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 194 Nursing Home 6 Other (Specify) Hospital: Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of e Hospital or Attending PI 24 hours after death. e Funeral Director: After the fetely filled in by the funeral 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tifle of certifie 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) me and address 32 Registrar's Signature Date filed (Month, Day, Year) State 9 Registrar

DHMH 17 Rev 1/2001

ORIGINAL